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# PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

*Editor:* MARY EDWARDS SHAW *Assistant Editor:* HEDWIG COHEN, R.N.

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

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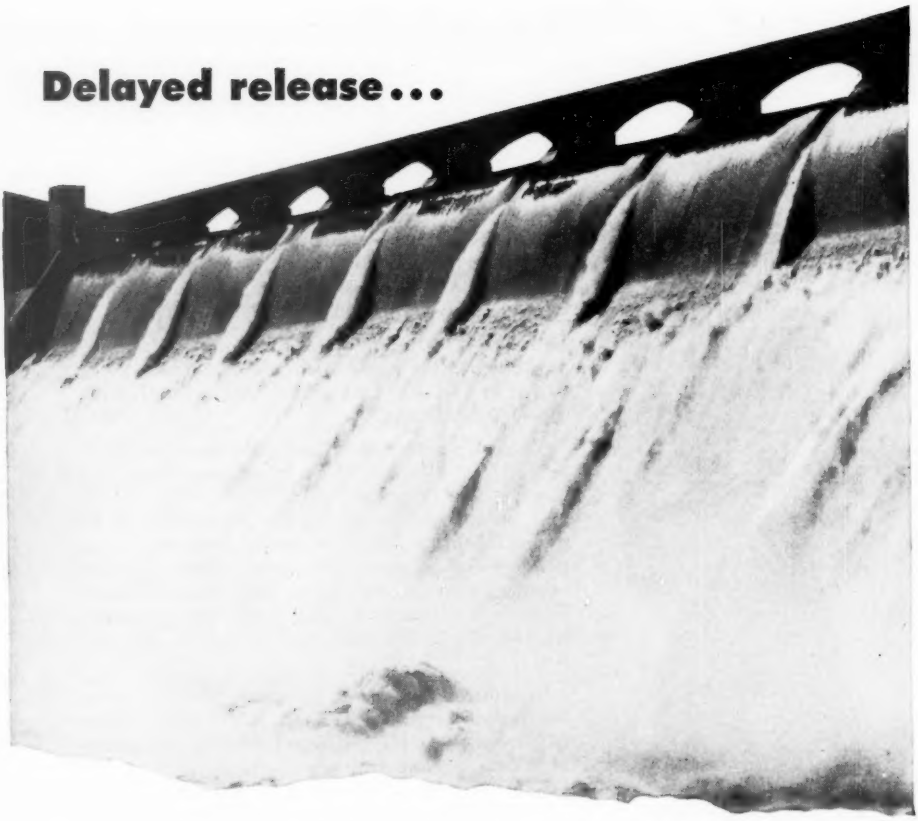

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# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## LOOKING AHEAD WITH NOPHN

SEPTEMBER brings with it the thrill of full-scale action. Vacations are over or nearly so. Rest and sun and a slight lessening of pressure have given at least a few moments for thought and evaluation of work done and that which lies ahead.

This is the time of year when the field nurse makes long-term plans for her district and its families, when she tries to see their needs and see them whole. . . . The supervisor plans for her staff. Has this or that policy proved good? Did the new conference scheme work? How can she work with both field nurses and administrator to serve best all her districts and families? . . . The administrator looks at her agency and its services and relationships to the broad community, be it city, county, or state. Is the money entrusted to the agency—whether taxes or voluntary funds—being used well and economically for the intended purposes? Are citizens aware of services available? Are they supporting the most important ones for the welfare of the community? . . . The officers and members of boards ask these same questions and ask themselves also, are we fulfilling the trust which the community has given us, not only by doing our part but also by having selected the best executive procurable, formulated policies that give her both direction and freedom to act to the best of her ability? . . . The board and staff and committee members of NOPHN are asking these same questions. We are ready and raring to go.

NOPHN has a busy program ahead, with important studies underway or about to begin, section and committee plans boiling, joint activities with other organizations demanding attention, and finally, needed planning for the year ahead. In all this there is the fascinating play of give and take between all parts of the country. Directly and through committee and section work each member has an active part. Ever public health nurse has a stake in the consequences. Every other citizen will be affected by what takes place.

Two regional conferences sponsored by the NOPHN to be held in Richmond, Virginia, December 6-7, and in Indianapolis, Indiana, December 13-14, will give board members, directors of agencies and of programs of study, supervisors, and staff nurses opportunity to talk over mutual problems. General meetings and discussion groups are being arranged to suit all needs. A special feature of each conference will be a one-day program on the nurse in the school conducted by the officers and staff of the School Nursing Section. A third regional conference for the west coast may be held just prior to the Biennial.

Rather unexpected this year has been the amount of time devoted to advising on prospective health and welfare legislation under consideration by the 81st Congress, much of which affects public health nursing. This important activity will continue through a strenuous second session next year.

Especially important to our general members is the long-anticipated rewriting of the old *Board Members Manual,* now out of print. The Board and Committee Members Section will collaborate with Mrs. Edith Wensley, the author, in the collection of new material and its arrangement.

Our great cost study is nearing completion. Soon agencies everywhere will have at hand the basis for an intelligent and accurate appraisal of the costs of their separate services,

and for adjustments in program emphases both as to dollars and cents and time spent. When the report is completed and published, the Working Committee will turn it over to the Cost Analyses Committee which will take over the responsibility for its interpretation, and for getting the new cost method into common use.

The possibility of combining all community public health nursing services, official and non-official, for efficiency, but at the same time preserving active citizen interest and participation has always appealed to thoughtful students of public health. Starting in September, NOPHN's study of forms which combination agencies take, their variations and modifications, their assets and liabilities, is expected to be an important contribution to the science of public health administration. The Committee on Nursing Administration is sponsor.

A number of other NOPHN committees have set dates for fall meetings. The Biennial Program Committee wants suggestions they can use in developing the kind of program wanted for the San Francisco nursing convention in May. The Nominating Committee is sending out a call for suggestions of nominees for 18 vacancies,—officers, directors, and Nominating Committee—for the Biennium 1950-1952. Since the ballot must be published well in advance of Biennial, quick action is needed.

The Education Committee and the Collegiate Council on Public Health Nursing (now a section of NOPHN) will hold their annual meetings in New York in October just prior to the American Public Health Association Convention. And the Collegiate Council will meet with the Council of State Directors of Public Health Nursing the same week.

The Mental Hygiene Conference in New York in November must be an invitation affair because of the specific job it has to do. The participants,—directors of programs of study in mental hygiene, instructors in this program, field supervisors of students, and resource people—will be especially chosen for the contribution they can make toward defining principles, policies, qualifications, and standards as they relate to mental hygiene in public health nursing. The conclusions and recommendations of the conference, however, will be of practical value to every nurse in the field and will be available to all.

The NOPHN is working together with other national nursing organizations in a number of joint committees. A considerable proportion of NOPHN staff time and budget go into the daily work of these joint efforts. Although most readers of the Magazine are familiar with their programs, mention of the special aspects of nursing they represent cannot fail to impress anew of the high degree of "jointness" already achieved at national headquarters. For example, the National Nursing Accrediting Service, after nine years of planning and organization is ready to begin accrediting the schools and programs of study in nursing on a joint basis. The National Committee for Improvement of Nursing Services (formerly the Implementing the Brown Report Committee) with Marion Sheahan as director, beginning September 15, has far-reaching functions to perform. Committees on structure, careers, nursing in medical care plans, practical nurses and auxiliary workers in nursing services, represent other areas in which combined action is more productive than action by one organization working alone. Committees, with NLNE, on postgraduate nursing education (which also includes ACSN) and advanced psychiatric and mental hygiene programs of study are continuing their work, as are the Joint Tuberculosis Advisory Committee and the Joint Council on Orthopedic Nursing and the special services they sponsor.

Does this sound like a big program? Truly what NOPHN can do in the year ahead is only limited by the manpower it has to command and the money it has to spend. A special advisory committee to the general director and the Finance Committee meet soon to relate work to be done with cash available. Their recommendations about priorities and program are discussed by the Executive Committee of the Board in October and final decisions are made by the entire Board next January. We could go faster and farther if every public health nurse and board and committee member in the country would take advantage of his and her opportunities to participate in the

national public health nursing movement through membership in the national organization and through personal service by affiliation with one of the five sections, or the 30 working committees, or by other direct contacts. Of all times in the history of NOPHN this is the year that calls for hard work of brains as well as brawn, and for continued financial support. Public health nursing has a big contribution to make to all of nursing and this is service to all the people. NOPHN is still the national organization *for public health nursing* and must continue its work full speed ahead until basic decisions about structure are made next May and orderly transitions are planned for and carried out.

# ON YOUR MARK, GET SET, IT'S CHEST TIME!

COMING Community Chest campaigns lend particular significance to the advice of Ulysses that: "Things in motion more catch the eye than what not stirs."

And a good way to get in motion is, of course, to look over the new material provided by the 1949 Campaign Promotion Kit in your Community Chest office.

You'll be particularly interested in announcements there of a new radio transcription "The Sweet Tooth," and a new window card, both of which are devoted to visiting nurse services.

"The Sweet Tooth" was prepared with the assistance of Hedwig Cohen, PUBLIC HEALTH NURSING's assistant editor. Your local radio station will like this human story of Gramps who thought that terms like "diet balance" and "diabetes" were "a lot of fol de rol;" of daughter-in-law Clara who quailed at his sulphurous pronouncements concerning doctor's orders; and of nephew Bobby, torn between love of Gramps and chocolate sodas. The visiting nurse and how she won Gramps' heart and confidence is portrayed with such realism that listeners will readily identify her with visiting nurses everywhere.

You'll want to keep in close touch with your chest's publicity director about the date "Sweet Tooth" will be broadcast and be sure that local newspapers are informed. Board members, volunteers, and other friends would probably appreciate a telephone call or a note telling them the time of the broadcast.

The "Sweet Tooth" transcription may be purchased for $5 to $30, depending upon your chest's directory classification and we're assuming that every chest with a visiting nurse association member will order it—along with transcriptions on 13 other chest services.

Legend of the new window and bulletin board card says "Give enough for visiting nurse service—and *all* Red Feather services through your Community Chest." The pretty nurse who holds the baby is Ellen Donnelly of the staff of the VNA of Brooklyn. Twenty-six years old, she is a graduate of the University of California School of Nursing and has an M.A. in public health nursing from Teachers College, Columbia University. She joined the Army Nurse Corps in 1945 and was stationed at Hammond General Hospital at Modesta, California, for a time, then at Fort McArthur, where she was chief nurse. Before going to Brooklyn she was on the staff of the New York City Health Department.

A picture or pictures of your own staff beside the poster will make a good newspaper story. Here is an excellent chance, by giving some background about both Miss Donnelly and your own staff to tell people once more that public health nurses are not only registered nurses but often have additional professional preparation.

The window cards are 11¾ x 16¼ inches and may be obtained for $7.50 per 100. Attractive 4 x 5 inch miniatures of the window cards may be purchased by your chest for mail inserts at $3.50 a thousand.

We mention these only as a starter. Once you're off you will find many helpful hints about chests and campaigns on pages 50-55 of the new manual, *Building Sound Public Relations*. After that—well, we trust that before the campaign is over your motion will be almost more than the eye can catch!

# THE NEW CHILD AT SCHOOL

ALFHILD J. AXELSON, R.N.

FACING the prospect of entering school for the first time, of going to an entirely new school because of change of residence, or of having a new teacher and a different room—these are the situations confronting our millions of school children in the fall. To many of them with their active imaginations these unknown factors can be frightening. All children need help in making the necessary adjustments.

This is especially true of the child going to school for the first time. "Entering school in itself," says Dr. Gertrude Hildreth, psychologist, "constitutes something of an emotional shock to many children who have never gone to school before. The mere fact of going to school the first year is a learning experience all in itself. . . . The six-year-old has many new adjustments to make and a bewildering array of new impressions to assimilate rapidly."*

Separation from home and his mother is in most instances the first radical change in his life. On that account the most important phase of his orientation at the beginning of his school experience is that of helping him feel at home in school. He is fortunate if his introduction to school is by a teacher who sincerely likes young children and is able to demonstrate this naturally, a teacher who is warm and outgoing. She appreciates that all children need and want affection; that the very independent, self-adequate child may have adopted this protective covering to hide his need for satisfying relationships with adults.

On the first day of school, provision should be made at the entrance of the building for the greeting of parents and children and the giving of necessary directions for finding rooms. This helps parents feel more secure and in turn the children, who are quick to respond to their parents' reactions. This is an important phase of planning for all parents and children returning to school the first day, not only for meeting the needs of new parents and children. The plans should be carefully worked out by teachers and older children in the school who can assist in this orientation. Each child should know what his function is to be in this process.

Other adults in the building, with whom the new child may have only incidental contact, as the janitor, elevator operator, and clerks, should understand the importance of respecting children and, if the occasions arise, of helping them to find their way about the building. Especially should such persons avoid any teasing, which young children do not have the maturity to take, about the ogreish character of the teacher or the unpleasantness of school. To ensure a constructive approach to children by service personnel

*Miss Axelson is teacher-nurse in the experimental New Lincoln School, New York City. She served as chairman of the* NOPHN *School Nursing Section from 1944 to 1946.*

* Hildreth, Gertrude. Learning through experiences in first grade. *Childhood Education,* National Education Association, Washington, D. C., November 1944, vol. 21, p. 121.

sometimes requires direction on the part of the administration.

An invitingly attractive school room which older children and mothers of the group may have assisted the teacher in arranging also helps the child to feel welcome. In it there should be placed ready for use a variety of materials that will stimulate activities,—easels equipped for painting, building blocks, puzzles, and books with gay covers. It should also have a definite space, a hook or locker for wraps, and a desk, locker, or part of a shelf for materials, reserved and waiting for each child, a place of his own as in a well arranged home. These are usually marked with both his name for the benefit of the teacher and a symbol or picture for each child which he quickly learns to identify as his.

This kind of a set-up usually facilitates the difficult problem of a child's prompt leave-taking of the parent who has brought him to school the first day, especially if there has been definite home preparation for this so the child knows what to expect. But the child is apt to watch closely parent-teacher, parent-nurse, and other parent-staff relationships, not only the first day but until he is adjusted to school. In his apprehensiveness he can readily sense any lack of mutual respect and friendliness. If this does occur it is unfortunate, for much of a young child's security in school depends upon a feeling of continuity between home and school, an important contribution to which is reciprocal parent-teacher respect.

IT HELPS children to acquire a sense of belonging, of being accepted and recognized if the teacher, nurse, and other adults with whom they come in contact quickly learn their names. Being spoken to by name—and it should be Robert instead of Bob if that is what he is called at home—means a great deal to children, for their names have special importance to them. This fall during the first week of school, one boy, a six-year-old, came up to the writer in the hall and said anxiously, "I bet you don't know my name." She admitted that she did not but would like to know it. When she saw him the next day and greeted him by name the tension in his face momentarily eased as he smiled broadly. But for a number of weeks he continued to inquire of adults in the school if they knew his name, the reason being, the writer learned from his teacher, that an assistant in the room had unfortunately confused him the first day with another child whom he resembled. Although she had quickly corrected the mistake, the experience bothered him.

Many teachers facilitate name learning by having children for the first few days wear their names printed on slips of paper pinned to the front of their clothing; the teacher also wears her name in the same way. The latter is a service to parents particularly, for seeing a name in writing is an aid in remembering it. Although this kind of labeling may be distasteful to some persons, it is a great help in the whole process of first-day orientation in school if all staff members, parents, and children wear their names. If the school is not too large, parents and children may have their names written for them by members of the welcoming committee at the entrance to the building.

With the first day of school a group of new children must begin to experience living in their own room, with all that means in the way of adjustment, even with the help the most expert and sympathetic teacher can give. A strange environment, including a different kind of bathroom, with many regulations for its use! New experiences that may seem meaningless, such as health inspection and a limitation of free activity, especially the possible requirement of sitting in one place for a crampingly long time for muscles that developmentally require frequent movement! And often most difficult to accept—20, 30 or more contemporaries, when possibly, if a child has not been to nursery school or kindergarten, he has not been in contact at one time with more than one or two children of his own age! And mother out of the picture!

A principal well known in the educational profession with whom the writer talked about this article, emphasized the need for public health nurses and others working with children to appreciate this emotional impact upon

children of their first day or days in school, even in a school that tries to make the utmost provision for the wholesome development of children. It is understandable that in the process of orientation some children, especially those who are somewhat emotionally unstable, experience nightmares, revert to enuresis, and frequently lose weight.

To try to prevent these undesirable reactions and to capitalize upon children's natural, buoyant anticipation of new experiences, much attention is being paid today to children's readiness for school. In an article, "Get Ready for School" in the June 1946 *Parents' Magazine*, Arthur L. Rautman discusses this readiness, which is a matter of physiological development, of training, and of experiences. In brief, these are the abilities he says children need to be successful beginners in school: (1) To have maturity enough to get along without parents for a reasonable number of hours; (2) To be able to go to and from school without assistance from parents or older children; (3) To be able to speak clearly and to express themselves in short sentences of three or more words; (4) To know how to take care of themselves at the toilet, to use a handkerchief without help or reminders, to wash face and hands without help, to dress without help; (5) To be able to play reasonably well with other children and to play by themselves for definite periods of time; (6) To be able to listen to a simple story until it is finished.

If children of six years cannot learn to meet these requirements within reasonable limits, many psychologists feel parents should seek expert help on the advisability of waiting to send these children to school until they are more mature, especially if the school makes little allowance for individual stages of development in first graders, for it is important that children have a feeling of success in their first school experiences.

It is evident, at least, that children's orientation to school starts at home. And because of this there is much that school nurses, public health nurses, can do to help parents in this process. In nurses' home visits and preschool health conferences they have opportunity to discuss with parents before-school-entrance experiences that should be of value to children in their school adjustment. They should encourage parents to arrange for brief separations of their children from home, such as occasional days with a relative and visits in the homes of other children. They should talk with parents about the desirability of planning to have their children meet at least some strangers and to play with small groups of other children. Nurses should stress the importance of parents' taking advantage of children's questions and other natural situations to discuss, over and over again with them during the summer, what school is like, for children need to grow accustomed to what to expect in school. Nurses can be more helpful in the latter respect if they know the routines of the school, particularly if they can tell parents what the program of the first day of school will be. These and other phases of children's self-reliance important to their success in school, such as ability to dress themselves and to cross streets safely, nurses and parents can profitably consider together. It might even be helpful for some parents, especially those who are apprehensive about their children's adjustment to separation from home, to anticipate that after their children have been in school a while the teacher may succeed them, the parents, as an authority.

School readiness means also being physically sound, having optimal health. The complete medical check-up desirable for all children about to enter school, even those who have been fortunate enough to have continuous medical care from the prenatal period, should preferably be given early in the summer. Remedial defects can then be corrected well in advance of school and commonly accepted immunizations carried out, such as revaccination against smallpox, if this has not been done since infancy, and "booster" treatment against diphtheria, tetanus, and pertussis. No child should have to begin school with the handicap of malaise from recent immunizations or corrective treatment,

and of a possible emotional tie-up between his fear of "needles" as many children refer to this prophylactic treatment, and the beginning of school.

And for that exciting first morning—and all mornings of school—children need to be fortified with an ample breakfast. This is so obvious that it should not need emphasis. But, many school health emergencies, the writer has learned, are due to the lack of breakfast and its concomitants—poor regimens that admit of late bed hours with resultant late rising because of fatigue, and in the frustrated hurry, quickly snatched breakfasts or no breakfasts, with frequent, complicating emotional upsets. It helps children to have their school schedules adjusted well in advance of the beginning of school so that they are accustomed to them. The rising hour should be early enough to allow for a calm period for dressing and for an adequate breakfast, a pleasant period with no adult intrusions or attempts to unravel knotty problems of behavior. For children need to go to school with a happy confidence in their ability to cope with the school day. Much of the success of that important first day depends upon this.

If children have had the advantage of attending a school "At Home Day," they are also better prepared for their first day. Many schools arrange for open house, a day or a few days before school begins, when parents and their children are welcomed to explore the school set-up, meet the principal, teachers, school nurse, and other special teachers. To children beginning their school experience this is particularly helpful, for just knowing who their teacher is, seeing the equipment and meeting and playing with the other children removes much of the uncertainty of the unknown connected with their first day of school.

In some schools, arrangement is made during this activity for a short meeting of all parents so that their questions about the school can be answered, and parents can learn from the staff members concerned about special phases of the curriculum, including the health program.

Before school begins, the school nurse and first grade teacher should arrange to have a conference, especially for the purpose of having the nurse discuss with the teacher health data of the children. The teacher needs to know particularly about special health problems and possible necessary modifications of children's programs. At the same time, the nurse has an opportunity to give the teacher information that might speed her knowledge of the children as persons. It might, for example, help Johnny in the valuable process of tying up home with school to have the teacher ask him the first day about his pet dog or to have her ask Sara about her big brother of whom she is particularly fond.

This is also a logical time for the teacher and nurse to decide if morning health inspections will be omitted the first few days and when they are started to discuss how they can be made meaningful to these new children.

To introduce children to school more gradually, to associate with large groups of their peers, some schools stagger admissions of first graders the first few days or first week. Some of the children, especially those who have not been to nursery school or kindergarten, may come every other day, the first week. If a child has a difficult time adjusting, he may continue this program longer, or he may stay at home a day in the middle of the week, or may have other adjustments made that fit his needs.

Teachers of young children with whom the writer is associated take care to limit as much as possible young children's experiences to their own room until they have become reasonably well orientated to this situation. This may take a number of weeks, after which the children are ready to explore other places in the building with which they need to become acquainted. For example, they visit the health room where they meet the nurse, whom they are apt to know already, and the doctor if he is in the building, and they have their questions answered about phases of the set-up. They may want to know about the various articles on the first aid table, what the cots are used for, and the like. In this way they get an introduction to the use of the

health room. The health room should be attractive and have as part of its equipment a low chair and table for young children. If children need for any reason to wait even for a short period a few colorful books on the table or other materials which interest them and which suggest their home room, seem to help allay any apprehension they may have, especially if they have not been to the health room before.

Physical examinations of these children, if they have not had examinations during the previous summer or if private physicians are not responsible for them, are usually not given until children are well adjusted to living in school. Then the teacher, the nurse contributing what assistance the teacher may request, carefully prepares the children for the experience. They need to know, on the level of their ability to understand, the purpose of the examination and what to expect—how much clothing they will be asked to remove and what the steps in the procedure are.

BUT CHILDREN who have been in school before also have problems of orientation at the beginning of school. The child who has just moved into the community is one of these. The genuineness of the school's interest in his welfare, the friendliness of his welcome by adults and children may help to determine how well he overcomes what is often the shock of being uprooted from his former school associations and how successful he will be in becoming a part of the life of the new school. With skillful guidance on the part of the teacher, children learn how to plan to include this child in their group, the children growing in their own social-personal development in the process. Usually, in the school with which the writer is associated, one child in the group is selected by the teacher especially to help guide the new child in his room and in the building. The child who is selected may be one who needs this kind of recognition for his own development. It may be a child who can be helped perhaps in overcoming his own shyness by being adequate in assisting someone else.

The nurse in her contacts with this child can also be helpful to him in his adjustment. Her friendly interest in him during a health conference, which may be a preparation for a physical examination—if no health records have been transferred for him, is an additional evidence of the welcome by the school. If the child has an opportunity during this time to talk about his former school, it often relieves bottled-up lonesomeness and helps to give him a new perspective.

Many schools today try, in various ways, to prevent anxiety of children because of their going back to school in the fall to new situations, new rooms, and new teachers. In general, a school may contribute to this by helping children feel they are not just members of one limited age group, but of the school as a whole. This school makes it possible for children to have more inter-grade contacts, more school-as-a-whole activities, and works for continuity and consistency of education. If, as in some schools, which is true in the new Lincoln School, many children are in "inter-age groups," combined groups of children of two or three age levels such as 3rd-4th-5th grades, 4th-5th-6th grades, or 7th-8th grades, the strain of adjustment at the beginning of the school year is greatly reduced for many children by their possibly remaining in one group with the same teacher for two or three years—although this grouping naturally has a broader and more significant developmental purpose than this. The above is also accomplished by having, as some schools do, a teacher stay with a group for two consecutive years.

When children are to move into a decidedly different situation in the coming school year, many schools arrange for experiences in the spring that will help these children in their adjustment. They may spend, individually or in small groups, a day or a part of a day with the group whose teacher they will be with the next year. If children, who have been having their lunch in their rooms, are to eat in the cafeteria the following year they will have opportunity in the spring to experience this complicated procedure.

In many school systems, entrance to high school represents a definite break or change

in a child's education, although ideally it should not. In the former Horace Mann-Lincoln School, students of the upper class groups took considerable responsibility for helping to orient new students. One summer, a committee of the student council prepared, with the guidance of a teacher adviser, a handbook which gave pertinent information about the school, particularly its operating policies, including health policies. Thinking through this material was undoubtedly of most value to the students who did the work, but the booklet was given as a reference guide to new students who assembled, as it was customary for new students to do, in a special room the first morning of school. Here they had the opportunity to meet all special teachers in the school, the physical education teachers, household and arts teachers and the nurse. At this particular time, the handbook was reviewed, and students had an opportunity to ask questions about it, to discuss it. New students in small groups, were also always conducted through the building by students familiar with the school. It was also helpful to new students in finding their way about the building to be able to refer to diagrams of the layout of each floor. These, made by students, were posted in a conspicuous place on each floor.

Theoretically, if a child's education is successful he proceeds from one experience to another smoothly and serenely, never suffering any upheavals of change. Because of wise orientation, new experiences always have a familiar aspect, have some relation to what has happened before. In other words, orientation is ideally a continuous process.

## WORLD HEALTH ASSEMBLY, ROME, JUNE 1949

The representatives of 70 countries at the WHO Assembly at Rome in June reached agreement on international cooperative measures for world-wide health improvement during 1950, within the framework of a $7,500,000 regular budget. Under the supplemental budget fixed at $10,500,000, representatives agreed on a program designed to raise health levels, especially in under-developed countries, as part of UN's project on "technical assistance for economic development."

Dr. Karl Evang of Norway, newly elected president of the Assembly stressed the "new outlook" in international health, WHO's aggressive approach to world health problems, and the change from curative to preventive technics in public health. He urged consideration of the close relationship of health conditions and economic problems. He declared that unless the people of the world enjoy a higher degree of both physical and mental health, the plans of economists to improve world economic conditions will not succeed.

The health demonstration area approach to health betterment will be given its first application in 1950. This envisages careful selection of areas in various parts of the world where a combined attack on a number of major health problems can be made simultaneously. In each there would be at least one large-scale disease problem like malaria which is susceptible to eradication. Combined with this attack measures would be carried out to improve overall health by applying new and positive technics in maternal and child care, health education, occupational hygiene and other aspects.

WHO will work closely with the Food and Agricultural Organization to increase the world's food production by a combined assault on diseases like malaria which oppose agricultural development and by application of new technics for increasing soil yield.

Recommendations of the World Federation for Mental Health for a large-scale program on mental health were approved. (See also PHN, May 1949, page 252, "Mental Health in WHO.")

Other programs were adopted relating to training of medical, nursing, and other health personnel, environmental sanitation, tuberculosis, venereal diseases, and many other subjects.

# ADVANCED PREPARATION FOR NURSING

*Advanced programs change to meet changing professional needs.*

R. LOUISE McMANUS, R.N.

FIFTY YEARS AGO the first university program for graduate nurses was established at Teachers College because a group of pioneer nurses and a forward looking dean of a school of education recognized the need for advanced preparation for positions of leadership in the rapidly growing profession of nursing. The question "What shall constitute advanced preparation for nursing," demanded serious consideration then as now.

Although the nature of our advanced programs in colleges and universities may be markedly different from that first program, it is not unlikely that the purposes of our program are substantially the same—the preparation of graduate nurses for essential professional functions which are in advance at the moment of those required of the rank and file of the professional group, and which help the profession as a whole more effectively meet society's need.

The interpretation of the word "advanced" here assumed is exceedingly important for it implies planned forward movement from one plane or status toward known and accepted goals. This is in contrast to other meanings of the term which have primarily time and quantity connotations. Two points of reference always need to be made clear in discussing the term "advanced"—in advance of what and toward what?

*Mrs. McManus is director of the Division of Nursing Education, Teachers College, Columbia University.*

## CRITERIA FOR ADVANCED PROGRAMS

The starting point for an advanced program, the NLNE Committee on Post Graduate Nursing Education has said, should be the basic nursing program. I would like to define this criterion further by proposing that the point of departure be considered the level of the average basic pre-service professional program. It should advance the student toward a degree of professional competence beyond that expected of the average graduate nurse, for new functions that are on the growing fringe where the profession is striving to meet changing social needs, or for functions other than nursing but needed in specialized positions which nurses must hold.

A program set up to provide opportunities for graduate nurses to supplement their preparation in those areas in which their basic nursing programs were partially or totally deficient does not meet this criterion. Even though the instruction and practice experiences provided are new to the nurse, the function of a supplementary program is to bring her up to basic nursing level competence. A program which is concerned merely with an added period of study with more and more of the same kind of practice is not an advanced program either.

Many programs for graduate nurses have

been and, unfortunately, still are of the "added experience" type and provide merely for an extended period of repetitive practice with few new learning experiences provided as a part of the planned program. Though we learn only through experience, it is true that not all experiences are educative, John Dewey has cautioned. Experiences which are repetitive to the point of routine, which present few problems which demand thinking and reasoning and which require only an almost automatic response, not only are not educative, but are miseducative. Research on the effect of experience of professional judgment in nursing clearly showed, for the nurse studied, that professional practice or experience alone did not increase the graduate nurse's judgment.* There was found no increment in judgment associated with years of experience. The emphasis in the basic program had so concentrated on teaching and testing facts that habits of memorizing facts had been fixed. Repetitive practice had provided for so much overlearning that the ability to recall factual information tended to increase with practice, rather than to drop off as might be expected from the curve of forgetting.

When the group who had had, as graduate nurses, some form of organized study interspersed with practice was isolated and studied, there was found a measurable increase in judgment.

The second criterion proposed, therefore, is that advanced programs should provide new learning experiences, and these should include organized instruction which gives meaning to associated previous experience or concurrent practice, and should provide problems which demand solution by reasoning.

The use of the term "nursing education" program as a synonym or general term for all advanced programs for graduate nurses, when educational programs for nurses is meant, has caused considerable confusion. Many programs do prepare nurses for educational positions as teachers and administrators of nursing schools, directors of in-service educational programs for nursing service agencies. These are rightly nursing education programs.

Other educational programs prepare nurses not for educational positions but for nursing service positions, as head nurses, administrators of nursing service agencies, and the like. Still others prepare nurses for professional practice as specialists in clinical nursing fields. The fact that nurses who go into educational and administrative positions must forsake their practitioner status is reflected in the kind of program offered to prepare them for their functions.

Preparation for educational or faculty positions and for nursing service positions, while in advance of basic nursing, involves in reality an entirely new field of study, predominantly involved with principles and methods of teaching and/or administration with sometimes little or no emphasis on advanced study of nursing practice. Doubts whether such programs are advanced nursing programs have been sidestepped at times by using the term, "advanced programs for nurses." Similarly, doubts about the advanced nature of some of the advanced clinical programs have been sidestepped by calling them "programs of advanced study of clinical nursing." In any event, there is agreement that the positions prepared for are beyond those expected of the average professional nurse.

Advanced preparation in academic subjects or fields usually implies a concentration upon an ever narrowing area of specialization, yet simultaneously acquiring a greater depth of meaning or breadth of viewpoint in relation to the subject studied. This might be likened to digging deep into a mine to find a priceless jewel or new fact, or climbing a cone-shaped mountain to achieve a vantage point of ever wider vision.

Professional education, however, differs from academic or general education. In professional education the essential criterion for content is its utility, for it is concerned with whatever content is needed to prepare the worker to practice his profession. In contrast

* McManus, R. Louise. *The effect of experience on nursing achievement.* Contribution to Education 938, Bureau of Publications, Teachers College, Columbia University.

to the analogy for general education, professional education may be likened to drilling an oil well to establish a continuing supply of fuel for the worker, as well as building high on the mountain-top a radio tower to disseminate knowledge.

The function of professional education is to shape and sharpen the tools of service so that the professional worker can precisely render the service needed. This necessitates a selection of content in relation to the specialized task to be performed and organization of content towards its use in professional practice, rather than content selected and organized for systematic study and exploration of the subject matter field.

### PREREQUISITES FOR ADVANCED PROGRAMS

Advanced programs in academic fields and professional fields alike have as prerequisites the completion of an acceptable program leading to a baccalaureate degree, and are offered in graduate schools in universities. Although less than ten percent of the schools of nursing offer degree programs and the average academic status of graduate nurses is below the degree level, I would like to propose as a standard (in the sense of a banner which leads us on and which we are willing to follow) that to the point of departure or base line for advanced programs we add this desirable standard: that of a baccalaureate degree which qualifies students for admission to advanced study in universities. Increasingly, the majority of nurses will meet the prerequisite for advanced programs through basic professional collegiate programs, professional in their true sense as implied by Esther Lucile Brown. For some time to come, however, many nurses must first prepare academically through undergraduate programs in general education, together with supplementary nursing programs, to bring themselves up to full professional status—that is, the level equivalent in both areas of preparation to the product of the average collegiate school of nursing. If this new standard is accepted few of the programs which now prepare nurses for educational and administrative positions or clinical specializations will qualify as advanced programs, for they do not have as prerequisites full professional status or include a baccalaureate degree. Is it the standard that is too high or is the level of our program too low?

### CONCEPT OF TIME SPAN

There is considerable disagreement in many professional fields as to the unique qualities which characterize advanced content. Dr. Paul Mort, Director of the Metropolitan School Council, New York City, prepared a graph based upon his intensive study of developments in education.* This graph portrays a time span extending from the first recognition of a need, for 50 years, up to the time when after many trials and errors a satisfactory way of meeting the need was invented or devised. It took the next 15 years for the new method or educational principle to reach and be accepted and utilized by 3 percent of the schools. During the next 15 to 20 years, there was an increasingly rapid diffusion of know how, so that by the end of 30 to 40 years, it had been accepted by all but a few backward schools.

### CONTENT OF ADVANCED EDUCATION

Having this assignment in mind, I suddenly saw in his data what seems to provide a reasonable clue to the definition of advanced content in professional nursing. Advanced content includes the facts that have been discovered, information, concepts and principles that have evolved, methods and know how that have been invented and devised, and although proved successful and are known and accepted in a limited number of the research centers, have not yet reached the stage of more rapid diffusion to many other schools of nursing. Professional meetings and conferences, professional journals, books, and other publications, are tools of diffusion, but the most strategic tool is likely to be the advanced programs for nursing. The main function of advanced programs for nursing, it appeared to me, was at once three-fold: to do research to unearth new facts, to devise new methods

* Mort, Paul R. *Principles of school administration: a synthesis of basic concepts.* New York, McGraw-Hill. 1946. p. 200.

to meet nursing needs and to speed up the dissemination and diffusion of know how as rapidly as possible, thus reducing the socially costly lag between invention and widespread use.

Upon consultation, Dr. Mort stated that this was a logical inference from the data. In fact, he said, the very questions which were asked Ph.D. candidates five years ago to test their advanced knowledge of education were now questions which every bachelor's or master's candidate was expected to answer, and in a few years every classroom teacher would be expected to know. If this theory is accepted, the lag between discovery of the fact or invention of an improved method and giving the patient the benefit of the discovery can be effectively reduced. This will be insured by the simultaneous extension of professional knowledge through research in nursing and the extension of opportunities for advanced study of nursing.

Advanced programs must prepare nurses in methods of research as well as in methods of teaching and administering educational programs in schools and nursing service agencies.

There is more agreement about the methods of advanced education than about content. The changing demands of people for services of professional nurses make it impossible to predict all of what the student will need to know after graduation. Educational methods should start the student on a program of self-education by giving fundamental principles and insights and by establishing habits of thinking and reasoning about nursing problems that will enable her to continue to learn and to improve her judgment. In advanced programs emphasis on educational methods should be focused on development of ability to solve professional problems, while emphasis on content should be focused on the social, human and technical aspects of professional problems.

SUMMARY

These then are the proposals regarding "what shall constitute advanced preparation in nursing." Advanced programs shall have as prerequisites graduation from an approved basic professional collegiate school of nursing or equivalent supplementary program They shall be of a type and level equal to instruction in other graduate professional schools and shall lead to an advanced degree. They shall provide for selected individuals learning experiences new to the student and shall prepare her for a position in advance of any for which a graduate nurse can qualify without special preparation.

The content of advanced programs shall be concerned with whatever is needed to prepare professional nurses to perform their nursing functions with a higher degree of competence and expertness than is expected of every professional nurse, or for any added functions demanded of nurses in specialized educational and administrative positions in schools of nursing, and nursing service agencies. Advanced programs shall use methods which enable the student to be self-directing towards her own goals and establish habits of self-education, methods which equip her to continue to improve her own knowledge and practice and to add to the body of scientific professional knowledge essential to the improvement of nursing practice.

Both content and method in advanced programs shall be so related that they provide for the integration of humanistic and social, technical and professional content which will promote growth in professional and personal stature and prepare for leadership in constructive action in social and professional programs.

The purposes of advanced programs shall remain unchanged; the preparation of nurses for specialized functions which will enable them to promote continually the professional status of nursing while improving nursing and health services rendered to individuals, families, and communities.

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This paper was presented at the meeting of the Association of Collegiate Schools of Nursing in Cleveland, Ohio, April 30, 1949. It is published simultaneously in the *American Journal of Nursing*, September 1949.

# ADVANCED PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING

Definitions, Basic Assumptions, and Guiding Principles
prepared by the NOPHN Committee on Graduate
Education in Public Health Nursing

## DEFINITIONS

ADVANCED PROGRAMS

The advanced program of study in public health nursing, as the term is used by this committee, refers to a plan of instruction for the graduate nurse to develop the abilities essential for practice as (1) a practitioner of public health nursing in a specialized area (2) a supervisor (3) a consultant (4) an administrator (5) a teacher. The program is built upon basic collegiate professional nursing education.

Basic, in the educational sense means usually introductory, fundamental, and essential instruction. The implication is that it leads to more advanced instruction. (See "Postgraduate Nursing Education," *American Journal of Nursing*, December 1945, pp. 1058-59.) The basic collegiate professional nursing education should include study in the biologic, physical, and social sciences and in the humanities. It should include selected educational experiences in the following clinical areas: medical and surgical nursing including communicable disease, tuberculosis, venereal disease, obstetric nursing, psychiatric nursing and pediatric nursing, including care of children with cardiac and orthopedic conditions. It should develop an understanding of the social, emotional, and health aspects of nursing through an integrated program of instruction in classroom, ward, and outpatient department, with appropriate use of community facilities that provide opportunity for family health service in homes. It should also include the elements of management and teaching in any hospital unit. There is need also for the student to have an awareness of the problems facing the profession and a general method of solving some of them. Experience in rural and urban areas, as well as in private and public medical agencies and institutions, is desirable.

The advanced program in public health nursing is conducted upon a graduate level and leads to a master's or a higher degree. It is assumed that in general students should be permitted to undertake an advanced program only if they have had at least two years of experience under supervision in public health nursing. Advanced programs in public health nursing are designed for the expert practitioner or practitioner in a specialized field, the supervisor, consultant, administrator, and teacher.

The duties and experience requirements of personnel referred to are those described in "Recommended Qualifications for Public Health Nursing Personnel, 1940-45," PUBLIC HEALTH NURSING, January 1942, pp. 24-28, and "Recommended Qualifications: An Interim Report," PUBLIC HEALTH NURSING, May 1948, pp. 261-62.

* The Committee used as a guide the publication "Courses in Clinical Nursing for Graduate Nurses, Pamphlet No. 1." National League of Nursing Education, 1945.

## BASIC ASSUMPTIONS

In formulating guiding principles the committee has assumed the general truth of the following statements:

1. There exists in the field of public health nursing a body of advanced knowledge, appreciations, and skills beyond that which can be attained during basic professional nursing education.

Basic professional nursing education is designed to prepare the general practitioner rather than the specialist. It is concerned with the preparation of the practitioner for first level positions rather than for positions as supervisor, consultant, administrator, or teacher.

2. Abilities which are essential to the public health nursing specialist, supervisor, consultant, administrator, and teacher can be acquired most effectively through an organized program of instruction on a graduate level.

Additional preparation is necessary to equip the nurse to function in advanced positions in public health nursing. Although proficiency in certain areas can be attained through experience and an in-service education program, intensive study and organized education experience lead more surely and rapidly to the development of a high degree of effectiveness in performance.

3. The fundamental purpose of advanced courses in public health nursing is the development of personnel who can contribute to the continued improvement of public health nursing practice and education.

Public health nurses who are to be responsible for high standards of service must have a clear understanding of what constitutes good public health nursing as well as mastery of skills in supervision, consultation, administration, and teaching.

4. There will continue to be a substantial demand for well qualified public health nurses to act as specialists, supervisors, consultants, administrators, and teachers. It is the responsibility of the public health nursing profession to offer guidance in their preparation.

At present there is a dearth of qualified personnel in public health nursing. Ever-increasing expansion in public health programs, the nationwide development of local health units, the Hospital Survey and Construction Act, and the National Mental Health Act will increase the demand.

Professional guidance will involve responsibilities for planning educational resources on a national and regional basis. It will also consider the establishment of necessary standards in relation to content, facilities, and educational activities. Its object is two-fold: well qualified personnel and the basis for evaluating this type of education.

5. The development of advanced programs in public health nursing will take cognizance of previous and parallel activities in the area of public health nursing education or in closely related fields.

## GUIDING PRINCIPLES

In setting up certain guiding principles the committee recognizes the need for standards upon which practice can be based. The principles deal with such matters as organization and development of advanced programs of study and proposed statements which might be used as criteria for the practices and conditions characterizing these programs. They are based upon principles already established in the fields of general and professional education as well as upon the judgment of members of the committee. They are partially applicable at any level of nursing education and fully so in the advanced program of study. The suggested standards are high and every program of study may not be able to measure up to all of them. They are set up as goals to be attained.

### Principle I

Advanced programs of study in public health nursing should be majors established on a graduate level in an accredited university or college.

There are many reasons why such programs of study should be conducted on a graduate level by universities and colleges. These institutions afford the type of control and facilities necessary to the attainment of educational objectives and can obtain the cooperation of various agencies in building up the

total course. They can enrich the educational resources of the public health nursing field by providing instruction in professional subjects and related aspects of the physical, biologic, and social sciences. They can provide opportunity for contact with students in other departments or with students having related interests. A good foundation for future working relationships can thus be formed with other groups.

Sound public health nursing practice is brought into focus within the university for analytical study, development, and refinement.

It is essential also that advanced programs of study in public health nursing be conducted in universities or colleges that are already offering major programs in nursing leading to a baccalaureate or higher degree. Institutions in which there is no nursing department or school of nursing lack the professional personnel to assume direction of the program and be responsible for its coherence and unity of purpose.

CRITERIA

1. The division or department or school offering the advanced program of study in public health nursing is approved or accredited by an appropriate professional accrediting or policymaking body.

2. The organization and administration of the course is in accord with the general policies of the university or college, and contractual arrangements are made with cooperating agencies.

3. The advanced program of study in public health nursing is developed on a sound financial basis which assures stability, continuity, and satisfactory provision for education. Financial arrangements are made with cooperating agencies which enable them to offer an acceptable program of instruction and supervised experience.

4. Eligibility for matriculation on a graduate level in the university or college and in its nursing department is a prerequisite for admission to the advanced program in public health nursing.

5. Direction of the advanced program of study in public health nursing is delegated to a well qualified public health nurse. There is an adequate number of competent faculty who meet university and professional qualifications.

## PRINCIPLE II

Admission to graduate study in public health nursing should be comparable to the admission requirements in other departments or schools of the university. In addition there should be an experience requirement of at least two years in public health nursing.

A total scheme of public health nursing education should insure gradual and more or less regular progression from one state of learning to a more advanced state. The basic or undergraduate course in the corresponding area should have been broad enough to serve as a satisfactory basis for the advanced course which in turn proceeds to a new and higher level.

CRITERIA

1. Evidence is available that candidates for the advanced program of study in public health nursing already have achieved a degree of competence which is expected upon the completion of the corresponding approved undergraduate course.

2. Before entering upon the advanced course students are sufficiently experienced and mature to benefit from it.

3. At the completion of the advanced program of study the student gives evidence of having completed all requirements satisfactorily.

## PRINCIPLE III

An essential requirement in any advanced program of study in public health nursing is that there should be accredited field agencies available for instruction. Field instruction is an important part of any program of study in public health nursing.

CRITERIA

1. The field agency selected should be well established, sound in organization and administration, and should offer a well rounded program based on fairly typical community needs and resources.

2. The agency should have a staff group

sufficiently stable to insure safe and continuous service to patients and families in a situation not made artificial by a predominantly student group.

3. In addition to meeting the qualifications specified by the agency for the respective staff positions, the staff nurses should also meet the qualifications stipulated by the educational institution.

4. There should be an adequate number of qualified public health nursing supervisors and consultants to insure sound guidance.

5. A qualified assistant director in education should be responsible for the student program, and she should be eligible for university faculty appointment.

6. Written contracts are desirable to show the division of responsibility between the educational institution and the field agency, and to provide for closer correlation of theory and practice.

### Principle IV

The advanced program of study in public health nursing should afford opportunity for critical analysis of practical problems and should lead to the development in the student of sound methods of evaluation and experimentation.

There is great need for nurses capable of functioning creatively in nursing, of analyzing and improving nursing practice. Students who possess the necessary background and ability should be permitted to pursue some investigative study in their chosen field.

#### CRITERIA

1. The members of the teaching and agency staff foster a scientific viewpoint in the student and make it possible for her to learn about the methods used in the evaluation and revision of nursing practice.

2. Opportunities are provided for the comparison of different points of view toward methods and procedures used in public health nursing agencies, and for observation of them in operation.

3. Students are encouraged to evaluate the advanced program of study in public health nursing while it is in progress and to make suggestions for improvement.

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Reprints of this statement are available.

## RESEARCH STUDIES IN PUBLIC HEALTH NURSING SERVICE AND EDUCATION

Information has been received about the following research studies in the field of public health nursing. Inquiries about the studies should be directed to the universities. See also page 515 for news about periodical listing of studies.

**University of Buffalo**

A suggested Program for the In-Service Education of the Graduate Staff Nurse in the Social and Health Components of Nursing.—Field of public health nursing supervision. By Cecelia Petrie, under direction of Elizabeth Hanson, for master's degree.

*Summary of findings.* Review of major problems involved and the development of a suggested program for hospital staff nurses in preparation for initiating a program emphasizing social components in nursing.

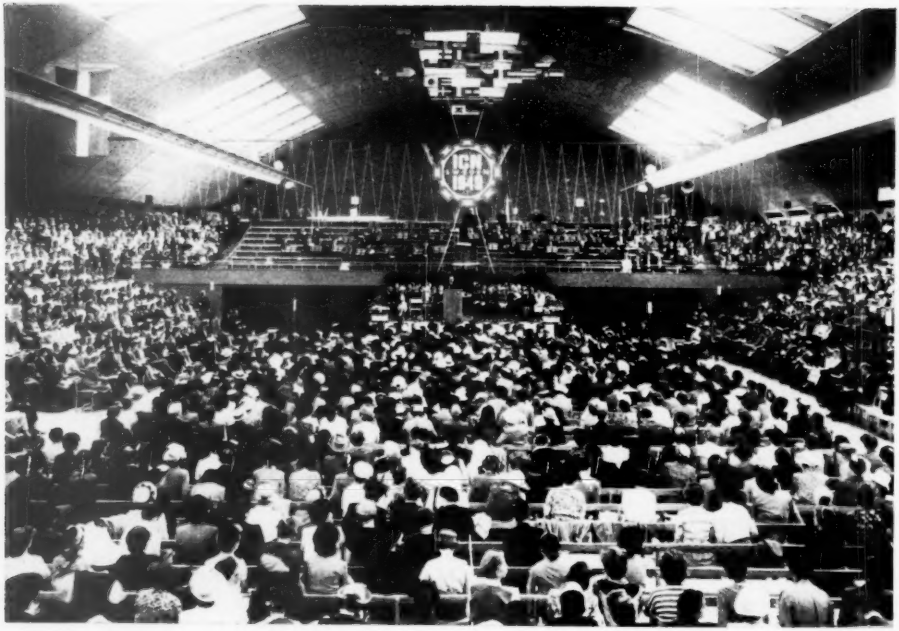
One copy is available on inter-library loan from the University of Buffalo library.

**University of Chicago**

Health Education and the Public Health Nurse in Health Education.—Field of public health nursing supervision, by Penelope Hope, under direction of Mary M. Dunlap, for master's degree.

*Summary of findings.* An analysis of data collected from interviews with health officers, health educators, and public health nurses indicated that there is need for clarification of terms health education and health educator; functions of health educator often not clearly defined and not therefore understood by health educator or others within the agency; frequent conferences between health educator and public health nurses should be planned to provide for better understanding of contributions which can be made by both. Because an orientation plan for the health educator is lacking or unsatisfactory, she is hindered in contributing fully to program of the agency.

Positive prints may be purchased from the University of Chicago Library.



# FIFTIETH ANNIVERSARY CONFERENCE INTERNATIONAL COUNCIL OF NURSES

ALMA C. HAUPT, R.N.

IT WAS TRULY an inspiring sight to look out from the queue on the steps of Stockholm's impressive modern Royal Tennis Hall on Sunday, June 12, 1949 and watch 4,000 nurses from more than thirty countries arrive to register for the Fiftieth Anniversary Conference of the International Council of Nurses.

For several blocks below, one could see women approaching on foot, streetcars jammed to the doors, and an occasional taxi, all leading to the Tennis Hall. Some of the women were in civilian clothes, many others were in a variety of uniforms, those with veils and capes adding a lively flutter to the scene. The way of some ten blocks was bedecked with the flags of the nations represented. The entrance grounds contained "a modern Swedish built and equipped fluorographic survey bus" (to us a mass X-Ray truck), a horse drawn ambulance of the 19th century, one community and two private ambulances, and a helicopter used as a flying ambulance. Guests were taken up in the helicopter. It was fascinating to watch its performance. After a vertical ascent, it would seem to stop in mid-

*Miss Haupt is director of the Nursing Bureau, Metropolitan Life Insurance Company, New York.*

air; then, like Stephen Leacock's horse, to go off in all directions, only to come down to within a few feet of the ground, fly horizontally, rise again, and then land. This is a particularly important type of ambulance in the Northern countries with their many islands and rugged terrain.

The queue gradually moved from the steps to the inside of the entrance hall where we were greeted by hospitable Swedish nurses as guides. Of first importance was a bank for the changing of foreign currency. At the registration desk, one was referred to the reception desk—a series of counters running the whole length of the ramp at the top of the hall. Behind each counter were individual post boxes for each registrant,—listed according to country and manned by Swedish nurses. Visitors were urged to check at the reception desks each day for mail and messages.

Upon registration, each one received a big blue cardboard folder, so arranged that the contents could not fall out. In it were the practical necessities for the week ahead—the program, a bound pamphlet of the Congress papers in the registrant's language, a map of Stockholm specially marked with places of interest for conference members, and tickets and instructions for the various meetings and performances. It was good to have registered on Sunday, for it took about half a day to read through all the material and become oriented to the coming program. By then the appetite was well whetted.

The conference hall opened on a corridor which extended around the whole circumference of the interior at the level of the top seats. One looked down on the vast auditorium with the stage at one end, and the main floor surrounded by a continuous balcony of seats. At each end of the auditorium and separated by partitions which went only part way to the roof, were the very modern exhibit spaces, one containing public health displays and the other, hospital facility displays. The roof of the auditorium was of glass which, together with the absence of partitions and the spaciousness of the whole interior, gave an unusual effect of light, airiness, and dignity. Add to this the decorations—the flags of the nations represented, huge replicas of the conference badge, and gorgeous flowers on the stage,—and you have the setting of the conference.

The conference badge was a blue world globe imprinted in white with "I.C.N. Sweden 1949" and surrounded by a chain of silver links. Miss Karin Elfverson, acting president of the Swedish Nurses Association, said in her greetings to the conference: "The nurses of Sweden have been given a great opportunity by being allowed to receive colleagues from North, South, East and West. Friends who perhaps have not been able to meet for many years—separated by land or sea, war and suffering—are now able to join hands in reunion. We are indeed happy that you have wanted to come here and that those who have suffered more than others by the war, are here today among friends. We regret that our colleagues from the East are not with us; as a result several countries are not represented in the chain of nurses—of which this year's conference badge is intended as a symbol. The fine links—human love and sacrifice—have, despite their fragility, shown themselves possessors of greater strength and resistance than those of iron and steel, stone and concrete." She concluded: "Hospitality has been the high-note in the North from the days of the sagas. We nurses wish with all our hearts that you will feel the warmth of this hospitality which now flows toward you."

One of the most conspicuous and most appreciated examples of this hospitality was the arrangement made to feed the 4,000 members of the conference who made up the largest convention Sweden has ever had. We were notified in advance that, due to certain limitations of food and personnel, local restaurants were unable to cope with such a crowd. That did not daunt the Swedish nurses. They enlisted the help of a volunteer woman's organization and set up a cafeteria in St. Erik's Hall, a pavilion about ten blocks from the Tennis Hall. Each nurse was assigned a place for lunch and dinner at one of the two sittings and not only was well fed, but had an opportunity to rub elbows with nurses from

other countries and to meet her fellow countrywomen.

The organization of that cafeteria was one of the great feats of the Swedish nurses. In fact the whole program was so well planned and skillfully managed that the Honorable Eije Mossberg, who declared the conference open on Monday morning said, "The organization of this conference is evidence of the vitality of the nursing profession." In addition to the Swedish nurses, the grand council of the ICN—especially Miss Gerda Hojer, president, and Miss D. C. Bridges, executive secretary, and her staff—deserve, and, I am sure, have the gratitude of nurses around the world for the arrangements for, and the achievements of this meeting.

The program itself was a fine blending of professional and cultural interests. There were five general sessions, the first being opened and closed by the Stockholm Philharmonic Symphony Orchestra and Choir. The moving rendition of Beethoven's Ninth Symphony was a fitting welcome to the member associations readmitted since the war, and to the new member associations, and bound all members in its spell of harmony, lyrical beauty, and strength. Under the skillful and gracious presiding of Miss Hojer, addresses of welcome were made by several representatives of Swedish governmental and private organizations. Then, Miss Bridges gave a stirring review of "Outstanding Events in the History of the International Council of Nurses." She said in part: "Certain it is that the foundation of an International Council in 1899 was the culminating professional event of a century which had seen the rise of nursing from something which was considered 'suitable employment for women of the lowest class', to an honorable and scientific profession for persons of education and culture. The establishment of nursing schools; the advent of the 'trained nurse'; the growth and subdivision of her work into various and specialized branches, all serving the different needs of the community; a growing insistence on educational reform—these were the legacies of the nineteenth century to the twentieth; and, as an inevitable consequence of the rise and progress of nursing and a consciousness of its obligations to the community, came the need for, and impetus towards, professional organization, both nationally and internationally."

She also reported that "An organization such as ours must fulfil two main purposes, and this has been demonstrated throughout its history. Firstly, it must meet the daily demands of its many thousands of members; it must be a 'fact-finding, standard-making, co-ordinating body', responsible for the collection of information about nurses and nursing from all over the world and for distributing such information as and when required. Secondly, it must be prepared to undertake and continually pursue the paths of research into better methods of nursing education, leading to improved technics in nursing service; and the results of such research must meet the needs of all our member countries with their differences of history, temperament, and social conditions. But these activities, if they are to be performed wisely, need constant inspiration and guidance. It is to seek such inspiration and such guidance that congresses and conferences, gatherings such as this one, have been convened throughout our history in famous cities and beautiful countries in various parts of the world, thereby strengthening and enriching our professional fellowship. Moreover, 'it is good for the health of the world', said Miss Adelaide Nutting in 1912, 'when nurses gather together from the ends of the earth in such numbers and in such spirit'."

The other general sessions were devoted to the following topics:

"The Medicine of Tomorrow and the Position of the Nurse"

"Nursing Education—Methods of Clinical Instruction"

"Nursing Service—How to Meet the Demand"

Committee Reports.

The first of these topics was discussed by representatives of Sweden, Norway, Finland, Iceland and Denmark. Each speaker gave a review of medical and public health developments in his or her country showing the transition which is occurring in varying de-

grees from the curative only to the combination of curative and preventive services and the increased developments of medical care programs. Improvements in maternal and infant death rates were noted; the use of B.C.G. vaccination and mass x-ray examinations were hailed as means of tuberculosis control; the high mortality rate of cancer, especially in Sweden, was mentioned. Emphasis was given to the relationship of housing, economic and living standards, nutrition, and mental hygiene to the health of the people.

There seemed to be general belief in the application of the insurance principle as a means of spreading service to the people, the use of both public and voluntary agencies, and the bringing together of curative and preventive services through closer relationships of hospitals, health centers, and the professions.

It was emphasized that the functions of the nurse have changed and broadened with these developments and through the increased specialization of medicine itself. Dr. J. Axel Hojer, general director of the Swedish Medical Board, Stockholm, set the stage for a lively debate by saying, "The frontier between the different groups of medical personnel is, however, indefinite and very often is fixed by the number of doctors and nurses and the possibilities of obtaining other help, but it is really the medical staff which has been divided into (1) doctors (2) nurses (3) nurses' aids . . . I am wondering whether the time has not already arrived when we have to reconsider the old difference between scientifically trained doctors and practical surgeons in such a way as to talk about doctors with predominantly scientific training and doctors with a predominantly practical training and in the latter class include the nurses in question."

Norway answered that it has need only for the graduate nurse, not the nurse's aid. "We have no ambition to be called 'assistant doctors' but we hope to become excellent nurses." Miss Venney Snellman of Finland in commenting on Dr. Hojer's proposal, asked "When American nursing leaders are setting the goal of an academic degree for every nurse, are they speaking of the same thing [as Dr. Hojer is]? I venture to state that there is no division of opinion among nurse leaders that the most essential feature of the middle group [the professional nurse] must be the responsibility for the total nursing care of the patient." She agreed that in the future a new name must be found for the professional nurse in relation to her changing functions. Miss Elizabeth Larsen of Denmark pled for future planning of medical and nursing care together rather than separately and for better recognition by doctors of the nurse's first responsibility as the servant of the patient rather than as the assistant of the doctor.

Time and space permit here only this sampling of one of the sessions. Of the others, it is sufficient to say that American nurses were proud of the paper by Miss Lulu K. Wolf of Los Angeles on "Methods of Clinical Instruction." This was followed by a rare presentation of the philosophy as well as the methods of clinical instruction prepared by E. Kathleen Russell and M. Jean Wilson of Toronto. Universally an effort is being made to improve nursing education to meet the growing demands for nurses to fit into expanding health and medical care programs. At the same time nursing shortages are everywhere reported and attention is being given to analysis of functions, qualifications, personnel policies, organization and administration, in addition to education and recruitment methods.

Unlike many of our meetings, the final business session with its variety of committee reports was to me the most interesting of all. True to form, however, was the announcement of an increase in dues—from 8 to 15 cents per capita—and an appeal for contributions to help defray future expenses. But the unusual quality of the reports was the revelation of how so many nations can work together on a common subject. Miss Ruth Sleeper of Boston gave an excellent resumé of the Education Committee's progress in setting up minimum standards for Schools of Nursing around the world. The report of the Committee on Nursing Service by Mrs. Bethina Bennett of London was a scholarly review

*(Continued on page 505)*

# AN AUTOMOBILE PLAN FOR NURSES

*A report of an operating expense study*

JEROME APFEL

AUTOMOBILES operated by the nurses in the employ of the Metropolitan Life Insurance Company are owned by the nurses. Personal ownership gives each nurse a feeling of pride and responsibility which acts as an incentive to more careful operation and maintenance. This results in lower operating and replacement costs, eliminates restriction or control on the use of the car, and is generally more satisfying to the nurse and the company.

The Metropolitan plan provides for three elements of assistance to the nurse in the ownership and use of her automobile in visiting patients (1) a purchase allowance towards the initial cost of the car and its subsequent replacement (2) basic automobile liability insurance (3) a monthly operating expense allowance, and extra payment for incidental parking, bridge or ferry tolls.

The purchase allowance, paid under an agreement which provides for the use of the car in the Company's service for a three-year period, constitutes payment in advance for anticipated depreciation. This financial assistance is both welcome and necessary to the nurse in the initial burden of purchasing the car. If the nurse discontinues the use of the automobile in company service before termination of the three-year interval, whether because of resignation, destruction of the automobile, or for any other reason, she becomes liable to the company for repayment of the unused pro rata share of the allowance. Upon completion of three years' use of the car in company service, the allowance is considered fully liquidated, and the nurse is eligible for a replacement allowance applicable to the ensuing three-year period.

The initial purchase allowance is set at a rate which approximates half the delivered price of a standard low cost car, making it necessary for the nurse to contribute the other half of its cost. Thus the nurse shares the financial responsibility in reasonable relationship to her personal use and ownership. The rate of the replacement allowance is usually equal to most of the replacement expense so that there is little or no cost to the nurse in replacing her first car. The payment of these lump sum purchase allowances makes it possible to exclude payment for depreciation from the monthly operating allowance.* This relieves the nurse of the responsibility of systematically saving amounts otherwise paid monthly for depreciation, and tends to prevent continued operation of antiquated, unsafe automobiles at excessive operating expense. In effect, the company's advance payment is similar to a depreciation withholding plan to help the nurse in the purchase of a new car every three years.

Basic automobile liability insurance is provided on the nurse's car by the company under a blanket insurance policy with $5,000 and

*Mr. Apfel is head of the Accounting Bureau, Health and Welfare Division, Metropolitan Life Insurance Company, New York City.*

* The purchase allowance and basic liability insurance payments of the Company average more than $20 per month, making the total, inclusive of the operating expense allowance, over $40 monthly.

$10,000 limits for bodily injury liability insurance, and $5,000 for property damage liability insurance. The master policy is held by the company and a schedule of insurance coverage on her car is issued to the nurse. The policy protects the company and the nurse, both on and off duty, and thus gives assurance of basic liability protection. The nurse may obtain higher limits of liability insurance under the blanket policy than those provided by the company and may have her car covered by fire, theft, or collision insurance by requesting such additional coverage at her own expense.

The monthly operating expense allowance is expected to meet the average cost of using a car in company service and is, at present, $20 per month. The nurse is not required to submit a report of itemized expenses or mileage, and is accountable only to herself for the monthly use and expense of operating the car. Although it is likely that actual monthly expense outlays may fluctuate widely, the total annual cost of operation usually approximates the sum of the monthly payments.

The amount of the monthly allowance was determined by studies of mileage and expense in various locations at different times in the past. These studies, therefore, reflected variations in the area covered by the nurse, the character of the terrain, the extent to which the service includes rural or urban localities, and the size and variety of the case load. Frequently nurses in rural sections accumulate more mileage in covering the district, but spend less for garage or other fixed costs; nurses in urban districts may pay higher garage rent and other maintenance costs, but spend less money for gasoline because of lower mileage in their more congested areas. These factors tend to equalize the total cost of operation so that it becomes equitable to pay nurses working in different types of districts the same monthly operating allowance.

In addition to the monthly allowance, separate reimbursement is made on the basis of vouchers submitted monthly by the nurses for parking charges, bridge, or ferry tolls that they may be required to pay in visiting patients or in reporting to the office. These payments eliminate from the regular monthly allowance unusual expenses which may be peculiar to certain districts.

HIGHER COSTS in recent years have led to a general need for further information on the present cost of operating cars owned by nurses that are used in the service of their employers. The Metropolitan Life Insurance Company, in search of such information, initiated a study of automobile operating expenses among its field nursing staff operating cars in company service during the month of October, 1948. This was considered an average month with respect to nursing case load and seasonal driving conditions, midway between the relatively light summer and heavy winter periods. Also, the number of absences because of vacation, illness, and other reasons is usually more moderate in this month, thus making it possible to obtain a more complete picture of the active staff.

The study included the reports of 177 nurses operating cars in 34 states, of which 166, or 94 percent were Chevrolets which the nurses have been encouraged to purchase in order to facilitate administration of a uniform low-cost automobile fleet. Of the 177 cars included in the study, 176 were 1946 or later models generally in excellent condition.

The major items contained in the study report form were:

1. Daily mileage
   (a) On-duty
   (b) From home to work and return
   (c) Other off-duty and personal
2. The number of home nursing visits
3. The number of gallons of gasoline purchased
4. Operating expenses during the period of the study
   (a) For gasoline only
   (b) For other costs
5. Fixed expenses at other times during the year
   (a) For regular costs
   (b) For other reasons

In considering the use of the car in the service of the company, only the mileage on duty was used during the study period to determine the percentage of total expense chargeable against the business use of the car. Mileage to and from work was not taken into account as it is regarded as the personal responsibility of the nurse because salary payment and other employer responsibility be-

gins when the nurse reports for duty. Any other practice would tend to discriminate against nurses because of their place of residence. On an annual basis, personal use would also include vacation mileage and reduce the percentage of total cost charged against business use, but this factor was necessarily omitted from the study because it covered a month of active duty for all the nurses who participated.

With these preliminary explanations, the following tables developed from the study are largely self-explanatory:

Table 1 shows that the average monthly mileage on-duty for the nurses included in the study was 525, or exactly 50 percent of their total of 1,050 miles for the month. As a result, 50 percent of the total monthly cost of $31.84, or $15.92, was considered on-duty cost, well within the monthly operating expense allowance of $20.

It is evident, however, that the percentage of business use of the car is a significant factor in determining the amount of total expense chargeable against the use of the car in company service. This makes it necessary to consider the personal use of the car by the nurse in relation to her responsibility for its maintenance and operating cost. To the extent that the nurse may derive the benefits of personal use and share the total cost of operating the car with her employer, the plan of nurse ownership and expense reimbursement for business use is advantageous and is welcomed by the nurse. On the other hand, if there is no great interest in having personal automobile transportation, or if its cost imposes a difficult financial burden, it is important that this factor be considered by the nurse before she assumes the responsibility of owning a car when accepting her assignment.

The nurse who prefers to own a car, but finds it necessary or prudent to control its cost of operation and maintenance, can effect considerable saving by careful study and planning. The payment of a fixed monthly allowance based on average costs without the need for detailed mileage and expense reports may afford her an opportunity to effect personal economies. If the size of her district or the routes available make it difficult to reach certain remote locations, changes in the daily planning or routing of calls, or even adjustments in the area covered may be indicated. The nurse should ask for the help of her supervisor or employer in considering these problems, particularly when extra mileage appears to be unavoidable because of the size or nature of the district. Additional mileage and expense studies may be necessary to check on variations that may have occurred in the use and cost of operating the car since the previous study was made.

In the final analysis, it is intended that the automobile provide the nurse with efficient and necessary transportation in reaching her patients. If the time and expense of operating the car are kept in proper relationship to the job to be done, her automobile will prove a source of satisfaction and pleasure to her both on and off duty.

**TABLE 1. AVERAGE MILEAGE PER NURSE IN STUDY**

| | MILES | PERCENT |
|---|---|---|
| On-duty | 525 | 50% |
| To and from work | 213 | 20% |
| Other personal | 312 | 30% |
| **Total** | **1050** | **100%** |

**TABLE 2. AVERAGE COST DETAILS PER NURSE**

| | |
|---|---|
| Gasoline cost | $17.63 |
| Lubrication, minor repairs, etc. | 8.04 |
| Garage,* license fees, etc. | 3.82 |
| Basic repairs and replacements | 2.35 |
| **Total Cost Per Nurse** | **$31.84** |

* Average cost of garage, $5.36 for 106 or 60 percent of the nurses reporting this expense.

**TABLE 3. AVERAGE COST PER NURSE**

| | COST | PERCENT |
|---|---|---|
| For on-duty mileage | $15.92 | 50% |
| For personal mileage | 15.92 | 50% |
| **Total** | **$31.84** | |

**TABLE 4. OPERATING UNIT AVERAGES**

| | |
|---|---|
| Total cost per mile | $.030 |
| Total cost per visit | $.102 |
| Gasoline cost per mile | $.017 |
| Gasoline cost per gallon | $.262 |
| Miles per gallon of gas | 15.6 |
| Miles per nursing visit | 3.4 |

# THE NURSE AND FAMILY COUNSELING

MABEL ROSS, M.D.

THE PUBLIC HEALTH nurse has long had the responsibility of aiding in the preservation of the physical health of the community, and now she is also recognizing her important role in the mental and social well being of her patients. Because of her acceptance by the family and her intimate knowledge of their everyday lives, she is in an especially strategic position to help with problems of marital adjustment, or to phrase it better, with the whole area of family relationships. Family counseling is a far from simple matter. Inherent in every problem of family relationships is the whole picture of society, family patterns, and individual experiences and goals. Too often well-meant but destructive "advice" has added to the complexity of the problem presented to the nurse. In the course of her home visits, the nurse will be asked for advice concerning family problems, and she must be able to give a constructive response. There is no simple answer, and, as in every other health situation she faces, the public health nurse must reserve judgment and survey the situation carefully.

Despite those who view with alarm the "breakdown" of the family, the family remains the structural unit of our society and the most potent single factor in development of the individual's personality. True, the structure is changing over the years, but its importance remains. The patriarchal family organization was the society and the government at one time. As the social organization widened to include other families, the form of the individual family was modified. As long, however, as marriage was considered a social requirement and was planned and arranged by the family (often requiring consent of the governing authorities) with a view to the proper carrying out of family traditions, the preservation of a marriage was at least as much due to the social pressure as it was to individual interest. The parties to the marriage were carrying out a social and family responsibility in which hopefully they were also happy, but this latter was not the matter of chief importance. With the Western custom of the individual's choosing the marriage partner, the marriage becomes an individual responsibility, and with decreasing social pressure as support, the weakness of the persons concerned becomes more apparent. One has only to read the history of families with power (and therefore less bound by social custom) to realize that avoidance of, or inability to carry, marital responsibility is not a modern development. Although it is also true that the pressure and strain of modern civilization has a part in this apparent increasing breakdown of the family, the maturity of the persons responsible for the family is the chief factor.

Every family unit is a combination of at least two previous units which in turn were combinations of other families. Just as this family is setting the pattern of relationships for the children in it, so the pattern of expectation from marriage was set for the parents by their experiences in their own family. It is all too easy to overlook this and to expect all

*Dr. Ross is director of the Prince Georges County Mental Health Clinic, College Park, Maryland.*

families to fall into whatever pattern the interviewer considers the desirable one. Equally, many young people look for an exact pattern for a happy marriage and will ask "What is the *right* way to get along?" The nurse will need all her skill to help them find their own solution to this, in keeping with their own past experiences, expectations from marriage, and goals in the family and in life. Sometimes inadequate family experience as a child leads to demands of marriage beyond possible realization.

Mrs. B. was a conscientious young woman whose pallor and deepset eyes and intense manner were startling. The nurse came into the home to help in the care of a 4-year-old girl in a body cast. The mother was overstrained in following directions for the care of the child and was fearful of making a mistake, and her attitude toward her household duties just missed being obsessive. The nurse was as reassuring as she could be and waited for an explanation of the tension. After a few visits in which there was only approval of her care of the child, Mrs. B. began asking careful questions about other family relationships. It became apparent that there was constant bickering and conflict between Mr. and Mrs. B. Mr. B. was a hardworking young man, closely attached to his own family whom he wished to visit over all holidays and vacations. The two B. children were well mannered, but somewhat demanding and not too happy with other children.

In conversation, Mrs. B. gave her picture of an ideal home as a harmonious, mutually helpful group, with the father considerate, gentle, and romantic, and the mother calm, always equal to every emergency, and with the house immaculate, and the home duties efficiently dispatched. This conception of family life seemed very unreal. After further conversation, the nurse learned that Mrs. B.'s father deserted the family when she was very small, and her mother had been unequal to the care of four children, so had placed them in homes and with relatives for their whole childhood. Mrs. B. had always daydreamed of a home, but this was based on her loneliness, rather than being a modification of a satisfying family experience. She had met Mr. B. who was a quiet, religious young man and never doubted this was the life she would have. For the eight years of her marriage she had been struggling alone toward her ideal. Mr. B. had a totally different picture of a home. For him, quiet, comfort, and keeping expenses within income were of prime importance. He considered them settled married people and saw no reason for romance at their age.

The nurse began by discussing experiences of other families and encouraging Mrs. B. to visit other homes even if her own was not immaculate. Her aim was to help Mrs. B. learn that she was expecting too much of herself as well as of her husband and children. With this, she was encouraged to discuss with her husband her worries about expenses. He thought he could easily do better so Mrs. B. let him take over. Although he did not find it easy, he worked out a better plan and, with this, showed more awareness of her household problems. Both began to see that family life is something to be cultivated jointly and does not thrive without care. The two personalities are not changed, but, as both want a satisfying home for their children, they are working together, and both their successes and their dissatisfactions are now shared.

A SUCCESSFUL MARRIAGE is always the result of joint effort. If both parties can see that they have the same goal, the cooperative effort is sure to follow. This is not to say that the marriage will then be ideal, but it can begin to give the persons concerned the hope of achieving a marriage which is satisfying to them. It is always necessary for the outside adviser to remember who needs to be satisfied in this marriage. Marriage is, after all, a very personal affair.

As in every other aspect of health, the complaint in marital problems may be far from the real trouble. The complaint is a symptom in itself. The nurse then has to look for the meaning of the complaint before she ventures further. This is often seen in the young mother who complains of her husband's disinterest since the baby's birth, or perhaps she insists that he has taken no part in the care of the baby. Before reacting to this and lecturing the young father (not that she ever would), the nurse has some detective work to do. Is the mother asking for sympathy because she finds the baby a greater burden than she expected and has to project the criticism on her husband? Is she so tied down with detail that she has lost her perspective? Is she refusing to share parenthood with the father, but expecting him to admire her as the personification of motherhood? Is he afraid of babies and also afraid to ask about their care? Is he also tired by the details of his daily job and unable to cope with the new situation? Or is he objecting to the responsibilities of parenthood? Whatever the problem is, what light can be shed on it for the wife, so that she can evolve a way of working it out for herself, and at minimum cost to her relationship to her husband?

Too often, especially in talking with young parents, stress is laid on the sharing of sorrows. It is easy to share sorrow or tragedy. Even

bitter enemies can work together in time of disaster. In building a lasting marriage, the memory of a happy outing, the mutual delight in an amusing happening, the catch phrase which has meaning only for the family, the sharing of everyday pleasures, are far more important than the dramatic shoulder-to-shoulder facing of catastrophe. It is often the memory of these bright moments which convinces a person of the value of his marriage, but the freeing of such memories often requires all of a nurse's skill.

Mrs. G. was a young, active woman who had married an equally active man of a different national group. The marriage seemed a stable one and the children appeared happy. However, when the nurse came to visit the eight-year-old convalescing from rheumatic fever, Mrs. G. told her that she could no longer stand Mr. G. She hurried to say he was a good provider and the children liked him but that she could no longer endure being in the house with him. She objected to his manner of speaking, to his refusal to wear a tie, to his tipping back in his chair after meals. The nurse recognized the child's illness had restricted and worried Mrs. G. and thought this might be an important factor in her outburst; however, she only commented that the children did seem fond of their father. In subsequent visits, she encouraged Mrs. G. to tell Jack stories of earlier experiences in a mining camp and soon found her telling with enthusiasm of going hunting with her husband. With this, the nurse began pointing out the need of a vacation soon and assuring her that Jack was out of danger. Although the vacation was delayed, the nurse found the mother enjoyed entertaining the boy with her stories of roughing it. The boy's admiration of his father did not disturb her, and occasionally she made approving comments about the father. The nurse recognized that Jack's improvement played a part in the changed attitude, but the reliving of mutually enjoyable activity had also lessened the concentration on her husband's disapproved habits and Mrs. G. no longer said that she couldn't stand him.

IN ANY ATTEMPT to help in the problems arising in family relationships, it is essential to remember the strong sense of belonging inherent in the relationship. The police are accustomed to the wife who complains about her husband and then attacks the officer who comes to arrest him. To agree with or to disagree with the complaint may be the end of the nurse's acceptance in the home. Every marriage has positive factors which have importance for the two people involved. Each person has a different goal in marriage and will expect and receive different satisfactions in the relationship. Every complaint has to be viewed in this setting in order to be understood. Occasionally the nurse recognizes that the complaint is in reality a form of boasting. O. Henry's story of the tearful wife accusing her long suffering husband of not loving her because he did not beat her as the neighbor next door said her husband did, is not too unusual. The question which must always be asked is "What does this mean to them?" It often seems a simple move could clear the situation but unless both persons are able to make the adjustment from their own desires to preserve the marriage, any amount of good advice or talking like a Dutch uncle or authoritarian pronouncements are a waste of breath. The question which sets them thinking is often more valuable than much advice. "When did this begin?" "When did you enjoy going somewhere together?" "What do you really want her (or him) to do?" "How does he (or she) feel?" But here too the tone of inquiry can imply criticism, and tone and attitude are more important than words. It has been said "No one agrees with other people's opinions; he merely accepts opinions which agree with his." Bearing this in mind, one realizes that the job of the nurse is to find what the opinion of the people involved really is.

Whether or not the nurse is married, she will be inclined to identify with one or the other in the family. Her own experience or ideal of marriage and her observations will prevent a completely detached attitude. The more she is aware of this and the more consciously she avoids seeming to take sides, the better it will be for her and her patient in the long run. And just as she must continue to care for the ill patient who has broken every sensible health rule, so she may have to help the community salvage the lives of both parents and children when the parents are unable to make the necessary adjustments in spite of her efforts and those of community facilities for marriage counseling. The community's chief responsibility is the protection of the children, both for themselves today and because their future adjustment to marriage

and family will be affected by their experiences in their own family. Often children of broken homes never experience family cooperation and sharing.

Family formation is a mature concept. It requires willingness to share, both in joy and responsibility, and with an attitude of "our" not of "my" life. The planning for and caring for children is part of the concept and with it therefore comes the ultimate in a sense of responsibility as a citizen of the community, since the community very directly affects the family. But not all people who get married are thinking of family formation. They may be too young in years or experience to recognize the meaning of marriage, or they may be unable to see beyond their own interest in prestige, security, comfort, or convenience. Since the level of maturity, judged by the ability to share with others, varies so widely, the level of marital and family adjustment will vary equally widely. It is for this reason that family counseling is far from simple. Only by recognizing the variability of individual goals in marriage and the variation in patterns of experience and expectation can the nurse effectively aid families in solving the problems of personal inter-relationships.

# SANITATION AND THE PUBLIC HEALTH NURSE

"Sanitation is a way of life. It is the quality of living that is expressed in the clean home, the clean farm, the clean business and industry, the clean neighborhood, the clean community. Being a way of life it must come from within the people; it is nourished by knowledge and grows as an obligation and an ideal in human relations."

*The National Sanitation Foundation*

How to implement this philosophy was the subject of a two-day conference sponsored by the National Sanitation Foundation in Ann Arbor, Michigan, June 14-15. Representatives of 100 national health agencies considered methods of promoting greater public understanding of the relationship of a sanitary environment to a healthy community and of creating more individual and group responsibility for cleaner homes and neighborhoods. The conference adopted the following resolutions:

1. That an expanded sanitation program on a nation-wide basis is needed and should be developed as soon as possible; and
2. That the National Sanitation Foundation, in collaboration with official and voluntary organizations and agencies, be urged to stimulate and further develop such a nation-wide sanitation program; and
3. That the first efforts be directed toward the development of community-wide educational programs, and that special emphasis be placed on individual and group participation.

Dorothy Rusby of the NOPHN staff represented public health nurses at the conference. She reports the discussion carried a familiar ring. Citizen participation in a nationwide drive for cleaner communities will be heartily supported by public health nurses who believe in the fundamental principle that community health services belong to the citizens of the community; that such services should be initiated, planned, and carried on jointly by health workers and citizens.

Guiding and helping individuals and families to observe desirable health practices are part of the public health nurse's job. No small part of her work is concerned with the teaching of the principles of sanitation. Care of food, dishes, diapers, and garbage are among the topics she discusses daily in her round of visits in homes, clinics or schools. Finding out where people get their drinking water; what they do with their garbage; where the privies are located are among routine duties, particularly if she works in a rural area. The public health nurse will welcome more teaching materials on the subject and she will be glad to be one of a larger team. She will be on the alert for further suggestions from the National Sanitation Foundation and other participating groups.

# NURSING THE CHILD WITH RHEUMATIC FEVER

SABRA S. SADLER, R.N.

SUPERFICIALLY the outlook on rheumatic fever may appear discouraging since it is the leading cause of death from disease between the ages 5 and 20. To nurses, however, the outlook is encouraging in that much can be done for the patient and much can be done to reduce this mortality rate. We can do even more when we are informed about the disease, the present concept of its treatment, and what is expected of the nurse as one of the team of professional coworkers.

Since nursing and medical treatment depend upon the diagnosis—that is, active or inactive—it is important that the nurse understand this terminology because one of her responsibilities is to interpret the diagnosis and recommendations. When infection is present the diagnosis is active rheumatic fever, and when the infection is arrested or has become quiescent the diagnosis is inactive rheumatic fever. Physicians avoid the term "cured" because the patient may have recurrent attacks of active rheumatic fever.

## ACTIVE RHEUMATIC FEVER

Active rheumatic fever is a generalized infection and may be acute or subacute. This generalized infection involves the connective tissues in the body. When the symptoms are marked the infection is considered acute and the child is usually extremely ill. When the symptoms are less marked, sometimes hardly recognizable, the infection is considered subacute. It must be remembered that in the long drawn out subacute stage the rheumatic fever is still definitely active. The period of active infection lasts several months and has been known to last several years, although the acute stage may be remarkably short. Because of this and also because it is often difficult to elicit a history of an acute illness many cases of active rheumatic fever are missed.

*The nurse's observation is important.* She looks for the usual symptoms of any ill child or one who is substandard physically, and in addition, the more characteristic manifestations of the disease. First there may be polyarthritis or inflammation of many joints. There may be the perfectly described textbook picture of red, hot, swollen, painful joints, but it is also likely that there may be only migratory joint pains, perhaps from shoulder to hip to ankle to wrist, et cetera, or perhaps just stiffness of fingers and toes. For example, after prompting by the nurse, one mother recalled her son's difficulty in grasping his toothbrush in the early morning, and then later, his fork at the breakfast table, because of stiffness of fingers. There may or may not be joint involvement in active rheumatic fever.

The second characteristic manifestation in active rheumatic fever is chorea, sometimes called St. Vitus dance. Physicians explain chorea as an extra amount of infection in the covering of the brain. When this infection is marked there is almost complete incoordina-

*Mrs. Sadler is nursing consultant, Rheumatic Fever Section, Virginia Department of Health.*

tion of muscles. All of us have seen the classical case in the hospital, but do we really associate chorea with acute active rheumatic fever? And are we concerned only with the marked chorea case? Irritability, restlessness, clumsiness, inability to hold things, or personality changes may indicate a beginning chorea. For instance, a school teacher reported to the school nurse that a 9-year-old boy had suddenly lost all interest in his school work. Previously his work was above average. His mother, who also had noticed his irritability at home, admitted she had to force him to attend school since his release from quarantine from scarlet fever. The teacher wanted to refer the child to a child guidance clinic. The nurse suggested a physical examination first, even though, other than slight pallor and fatigue, there was apparently no reason for this sudden unexplained change. The pediatrician diagnosed the case as active rheumatic fever with chorea, and only after 11 months of rest was the child able to return to school, his usual self.

The third characteristic manifestation of active rheumatic fever is the rheumatic nodule. The nurse observes and teaches the patient and family to observe this little gristle which may be found on bony prominences. It is not painful and it may be overlooked since often it is as small as a grain of wheat, even though sometimes as large as an English pea. Some physicians claim that rheumatic nodules appear in pairs, that is, if there is one on one ankle, there is one on the opposite ankle. Other physicians have not found this to be true. Look or ask the patient to find these nodules, back of the ears, on the elbows or radius, on the metacarpal and metatarsal joints, and the like. A sensitive finger over the bony prominence can detect the gristle. Following a symposium on rheumatic fever, a student nurse discovered a nodule on a child's big toe and there was great glee in the ward, for the physician needed just that nodule to confirm his suspected diagnosis of active rheumatic fever.

The fourth characteristic manifestation of this disease is carditis. Although rheumatic fever is a generalized infection it has a special predilection for the heart. Not always but usually some part of the heart is involved before the disease has run its course. All or part of the heart may be affected at the same time. If a patient has myocarditis the period of bedrest will probably be a long drawn out affair; whereas with the polyarthritis form with little carditis, the physician anticipates perhaps at most several months of bedrest before the infection subsides. This knowledge guides the nurse in her teaching plan. She also knows that as long as there is some infection present the degree of infection may be aggravated at any time by a superimposed infection such as a "fresh cold" or a communicable disease. For example, one 16-year-old girl had convalesced long enough to be permitted automobile rides. Little did the physician expect the ride to result in exposure to and infection from gonorrhea, which irritated the subsiding rheumatic infection.

*What are some of the symptoms of carditis?* Certainly the obvious symptoms of decompensation, such as orthopnea, extreme dyspnea, marked increase in respiration and pulse rates, cyanosis of fingers, toes, and lips, and edema, especially of abdomen and legs. But there may be symptoms which are not readily associated with carditis, such as a child's preference for standing around the playground and avoiding active participation rather than ride a once cherished bicycle. Instances where the keen nurse has related the rapid pulse several days after a simple appendectomy and the patient's complaint of continued abdominal pain as indication of additional trouble, have resulted in a number of cases of correct diagnosis of rheumatic fever.

A 12-year-old girl returned to school after a simple appendectomy. When she continued to complain of stomach aches, the family physician suspected worms in spite of the negative stool specimens. But the observation of additional symptoms made by the teacher under the guidance of the county nurse—fatigue, epistaxis, failure to gain weight, palpitating heart—were reasons enough for the physician to refer the child to a consultative rheumatic fever clinic where the

diagnosis of active rheumatic fever was confirmed.

The nurse knows bedrest during the entire period of active infection is for the purpose of protection of the heart. The chorea or polyarthritis manifestations apparently do not result in residual mechanical damage. There may be scarring in the heart from the rheumatic infection. The point nurses must remember is that the physician treats the infection while it lasts in order to prevent and lessen the heart strain and damage.

Dr. Betty Huse of the Children's Bureau* has reminded us that the child dies from the infection when the infection is active, not from the mechanical damage,—the scar, or leaking valve, or rheumatic heart disease—after the disease has become inactive. Thus a child with rheumatic heart disease is no more likely to die because of the scar on his heart than a child whose tuberculous areas in the lungs have become calcified is likely to die of tuberculosis.

The physician attempts to minimize the strain on the affected heart by giving the heart as much rest as possible when the infection is present. Simply stated, he tries to spare the heart unnecessary beats. The estimate of beat saving each day when a patient is at rest and off his feet averages 10,000 to 20,000, depending on the age of the person and the degree of infection. For example, if a child with active rheumatic fever with a pulse rate of possibly 130 is put on bedrest, his pulse rate will probably decrease to 90 or below within one or two weeks. This imposed rest gives the inflamed heart the best possible chance to throw off the infection and repair itself.

Since there is no known specified medication for active rheumatic fever the physician helps nature along in this rest process by relieving the specific apparent manifestations with use of medications, and the nurse must be alert to expected and unexpected results of this treatment. If the patient has polyarthritis the physician may order salicylates, usually in the form of aspirin given in large doses. Nursing care involves not only giving the drug accurately but also observing whether or not the salicylates reduce the temperature and/or relieve the pain. Also, does the child develop symptoms of sensitivity to the drug or acidosis, as evidenced in changes in respiration, drowsiness, or stupor? If there is chorea, the physician may order a sedative, often in the form of phenobarbital. The nurse is expected to observe and report whether or not the drug seems to quiet the patient as intended. A sensitivity such as skin rash, itching of the skin, or so-called "drunk jags" should be reported immediately to the physician. For example, a 15-year-old girl on bedrest suddenly began giggling as if intoxicated. The nurse immediately connected the drug with this girl's unusual behavior and the medication was discontinued. When a diuretic is ordered not only must the nurse anticipate the need for a bedpan and measure the output of urine, but she must also observe and record relief of symptoms such as edema, especially of abdomen, legs, and dependent parts of the body.

It is usually the child with active acute rheumatic fever who requires medication. Seldom does the child whose infection has become subacute require much assistance from drugs. Although during the acute stage 24-hour skilled nursing service given in the hospital is desirable, many patients for various reasons remain at home. Detailed instructions in regard to accurate administration of medications is an important function of the nurses supervising the child's care at home.

When a child's diagnosis is active rheumatic fever, the nurse must begin immediately to make a plan for long-term nursing care and institute nursing measures for the child's total health as soon as possible. If the child is in a hospital, there are two points which the hospital nurse needs to remember (1) the danger of cross infection to this child and (2) planning for care at discharge at end of the short hospitalization period.

The danger of infections such as colds, sore throats, or common communicable diseases to the rheumatic child presents a serious problem. It is not that the rheumatic fever

* Huse, Betty. Rheumatic fever in children. *The Child*. May 1943, v. 7, p. 158-161.

patient is dangerous to others, but it is because of the danger to him that he should be segregated and visitors and nurses who have any symptoms of a cold should be excluded from the ward.

Discharge plans should be started the day the patient is admitted to an acute ward, for the hospital that accepts acutely ill children is not geared to take care of the subacutely ill. In the several places in which the author recalls this has been attempted, the results have been almost disastrous. The subacutely ill child has his three meals a day, his bath, his bed made. Yet the restlessness of this child who doesn't appear ill, when compared with the acutely ill in the same ward, often results in serious emotional trauma. A discharge plan as worked out with the physician and family may include transfer to a rheumatic fever convalescent hospital, to a boarding home or foster home, or to the child's own home. Nurses must remember that every child with acute rheumatic fever, whether the economic status of the family is excellent or poor, needs nursing assistance in planning for care and should be offered this assistance. Not long ago a 9-year-old son of a prominent judge was admitted to the hospital with acute rheumatic fever. The hospital nurses gave this child expert care, although they were timid about teaching his mother and discussing any possible followup care in the home. What was the result? Both mother and child had a stormy month at home until the county nurse heard about the case and, under the guidance of the family physician, offered to go into the home to help the family set up a reasonable rest routine to meet the child's needs. This particular physician, who thought previously that the county nurse looked after indigent patients only, now sends her into the home of all rheumatic fever patients prior to hospital discharge to plan a long term rest routine.

*What are the essentials of nursing care?* First, someone must give watchful care 24 hours a day. In the hospital this nursing service is provided. At home, a dependable person, usually the mother, assumes this responsibility. The mother, of course, needs periodic relief from her arduous task. Thus we help prepare a substitute, often the father, who is instructed in the elements of necessary care. Second, the child must be in a room apart from others in the home. This may require improvisation. Sometimes a room within a room, made by curtaining or screening off a section, makes a satisfactory sickroom. Planning for an ideal sickroom which includes adequate ventilation, lighting, heating, convenience to bathroom and home-nurse, may take several weeks to become a reality. The bed will be the home of the child for many months. For the acutely ill child an improvised hospital bed (single or three-quarters size) is preferable since care can be given from either side. As the acute phase subsides, and for long term bedrest, a substantial double bed seems to be best, provided the height is satisfactory for working (bed blocks help) and the mattress firm, and springs taut (boards under mattress aid). A urinal and small bedpan are necessary until the physician allows bathroom privileges.

Full support must be given the entire body and attention given to good body mechanics and posture fundamentals. When lying on his back the acutely ill child needs a firm footrest (not pillows), a kneeroll, and small pillows under forearms. When turned on his side he needs pillow support at his back and between his knees, and a small head-pillow. When fed he needs a low backrest as well as the footrest. When, in the subacute stage, he is permitted to feed himself he needs a firm, upright backrest, curved bed-tray-table, a kneeroll, and firm footrest. All this bedrest equipment can be improvised if necessary. In addition, sufficient bed linen and bed clothing are needed.

The psychological needs of the child with active rheumatic fever are the same as those of any other child. Yet, because he is apprehensive and emotionally unstable due to the nature of his illness, he needs understanding help and guidance. He should be disciplined as much as any well child is and assured of his place in the family circle, but not made the center of all attention. His social, emotional, and mental growth must be considered

at the same time he is getting his physical rest. Stressing the fact that bedrest, even though prolonged, is temporary and that he can look forward to normal activities at the end of the bedrest period, will help to keep a healthy attitude. Actually, in the subacute stage the nurse or family spends only about 10 percent of the child's waking time in giving bedside care. The child does much for himself, such as feeding himself, washing his face and hands, brushing his teeth, combing his hair, dressing himself.

A written schedule is tangible evidence of a regulated plan for the child. The schedule is rewritten whenever the physician gives added privileges. With guidance, the subacutely ill child enjoys writing his own schedule. He will be more likely to follow recommendations if he is given his share of responsibility. For example, a simple thing such as allowing him to set his own alarm clock before he begins his two hours required undisturbed after-lunch rest will make a great deal of difference in his attitude toward imposed restrictions.

Activities of the child with active rheumatic fever are planned carefully under direct orders from the physician. In the very acute stage, the nurse interprets the order of bedrest as "complete bedrest" and sees that all activity on the part of the child is passive. When privileges are increased, the nurse plans accordingly. The average child with active rheumatic fever who is put on bedrest is subacutely ill and the physician usually permits him to feed himself, brush his teeth, wash his own face and hands, have handicrafts, and home instruction, if properly supported with high backrest, curved bed-tray-table, kneeroll, and footrest. This patient is usually in a home or in a convalescent hospital. The activity periods must be interspersed by 5 to 10 minute undisturbed rest periods and the child must rest flat for one hour after meals and 20 minutes before meals. On non-school days he may be lifted to a comfortable armchair by the bed for his activity period or be lifted to a cot on the porch or in the yard. He uses the bedpan and urinal. Although he may comb his own hair, the nurse must give the bedbath. The physician will give promotions gradually and with caution. As restrictions are lessened during the many months of rest, the nurse continues to interpret his specific recommendations.

Careful attention to care of the skin including baths and shampoos, oral hygiene, elimination, diet, accurate recording of the temperature, pulse, and respiration, are a part of good nursing care. Recreational therapy is also an essential part. Non-stimulating diversional activities suited to the child's psychological and chronological age will assist in his emotional, mental, and social growth. Home instruction is most desirable during the subacute stage of rheumatic fever since it assists in inducing mental growth and keeps the child familiar with the regular schoolroom activities of his age group. It is often the nurse, with the doctor's permission, who arranges with the local school board for a visiting teacher. The nurse is responsible for familiarizing the teacher with the child's history so she can meet his individual requirements. The nurse can help the family arrange for suitable lighting, ventilation, and seating. The nurse explains to the family and the child that school at home is a serious business. Therefore, interruptions during school hours are discouraged and assignments are prepared as if in regular attendance at school. During the latter part of the subacute stage of active infection, the nurse investigates the possibility of a reasonable school schedule —hot lunch, convenient toilet facilities, cot for resting after lunch, transportation without undue exposure. The physician uses this information as a guide for orders when he finds the child is physically able to return to public school.

### INACTIVE RHEUMATIC FEVER

When the subacute stage has subsided into the inactive stage, the treatment is reversed. Formerly the child rested to get well. Now he is well, and we want him to remain well by using good health habits, many of which he learned while on bedrest, such as regular meals, elimination, good personal hygiene, and the like. The child will need assistance

in adjusting to a normal routine. He may even need to be persuaded to attempt the permitted activities. His family and teacher need help also, for it is difficult for them to accept the fact that this child, who was ill only a few months ago, is now back in school and permitted to do almost anything the other children do. The child may be among the estimated one third of those who get over rheumatic fever and have no residual heart damage, or among the one third who have a slight murmur, yet who carry on full activity, or in the last third, all but 5 percent of whom lead reasonably normal lives in spite of considerable mechanical scarring. The school nurse and teacher may have to plan satisfactory substitutions if competitive sports are forbidden. Of course forbidden drills do not include fire drills. However, many physicians believe the child who has just returned to school should fall out of line after the fire drill and leisurely climb the stairs to his homeroom, rather than march back in with the group. All these points should be interpreted to the teacher who might otherwise restrict the child unnecessarily because of fear of a recurrence of the disease. With correct interpretation rather than emphasizing restrictions, the teacher is able to observe signs and symptoms of fatigue, signs and symptoms which might denote a recurrence of active infection. She cautions the child against exposure to communicable diseases and urges medical care for any apparently unfavorable condition.

If the physician prescribes regular use of one of the sulfonamides in order to prevent a recurrent attack of active rheumatic fever, the nurse interprets the patient's and the family's responsibility, perhaps over a period of years, in the regular administration of the drug and the necessity for periodic blood counts.

Periodic dental as well as medical supervision should be stressed. And the nurse must be vigilant in her general health supervision, not only of the child but also of his family, especially the siblings, since this disease has a tendency to occur in susceptible families.

With a clear picture in mind of what rheumatic fever is and the care needed to combat it, let us start out on an active case finding campaign. If we find a sick child, let us help get him well and after he is well, help keep him healthy. In so doing we shall have the more than usual satisfaction of responding wholeheartedly to a real challenge in nursing today.

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# EMOTIONAL EFFECTS OF A LONG-TERM ILLNESS ON THE FAMILY

STEPHEN FLECK, M.D.

THE PROBLEMS that beset a family in which a member has been hit by rheumatic fever are by no means specific. Rather they are similar to those that would arise from any chronic illness in a child at home. In fact, it cannot be over emphasized that rheumatic fever is a problem involving the entire family as much as it does the patient, his heart, or his joints. The following example will illustrate this.

Johnny Miller was a 10-year-old, active, well adjusted boy, the oldest of three in an electrician's family. About one year ago he came home after his basketball exercise and complained of general aches, sore throat, and feeling very tired. His mother thought he had a slight fever and put him to bed. That evening he felt sicker and complained bitterly about his right arm hurting, especially around the elbow. He was no better the following day, so Dr. Smith was called. Dr. Smith talked to Johnny for a while, found him rather anxious and fatigued but responsive. He seemed mainly worried about the basketball schedule but did not mind very much losing some time from school as he had no worries about promotion to the fifth grade the beginning of the summer. On examination, the doctor discovered that Johnny had a sore throat, a systolic murmur, questionable enlargement of the heart, swelling and inflammation of the right elbow, and slight puffiness and tenderness of his knees. The doctor obtained some samples for blood studies, sedimentation rate and so forth. When he saw Johnny again he inquired into his special interests and found Johnny had been like most children. He had wondered something about the workings of a radio, for instance, but had never done much with mechanical things except play with them.

Doctor Smith then saw Mrs. Miller and spent half an hour with her, beginning first by trying to find out about her anxieties concerning Johnny's condition. She almost immediately said, "He doesn't have rheumatic fever, does he?" The doctor wondered why she asked that and learned that Mrs. Miller's sister Mary had died a few years before of rheumatic heart disease and that another relative was handicapped by chronic arthritis. Dr. Smith then said that Johnny might well have rheumatic fever but that it looked a good deal different from what Mrs. Miller had told him about her recent experiences with the disease, emphasizing that the constant struggle that had gone on between Mary and her mother was something that can be avoided and that it was not the parent's fault that the child was sick. He then tried to learn more about the family situation and discovered that Mr. Miller earned about $300 a month, there were some savings including a life insurance policy, and the family lived in a five-room apartment including three bedrooms.

*At the time of preparing this paper Dr. Fleck was instructor in psychiatry and assistant in medicine, Johns Hopkins University. More recently he has joined the staff of the University of Washington Medical School, at Seattle.*

The doctor said he would return the next day and that for the time being, Johnny should remain in bed and should be fed if he seemed weak and tired, but that if he appeared anxious to feed himself, to let him do so.

The following day Dr. Smith returned and found Johnny essentially unchanged. He had brought his electrocardiogram machine along and he explained it in great detail to Johnny before taking his tracing, likening the machine to a radio set and dropping a remark about radio hams. The EKG was normal but the diagnosis of rheumatic fever seemed definite enough to begin salicylate therapy. Dr. Smith again spent some time with Mrs. Miller. Several questions had arisen in her mind, such as, how long the other children had to be kept away from Johnny as they had planned to move the youngest child into Johnny's room soon. Johnny hadn't eaten well and had disliked being fed but Mrs. Miller thought it wiser to feed him despite his protests. Mr. Miller had raised the question of whether or not Johnny should go to the hospital and how much it might cost. Dr. Smith wondered how many friends Johnny had and if they had come to the house often, which they had. He said it seemed wiser to him to keep Johnny at home for the time being, provided the mother felt she could carry the burden and have somebody who could come in once or twice a week to relieve her of the nursing. He emphasized that the important consideration was to keep Johnny in bed for some time to come but that being in bed did not mean rest unless the family would help him to rest. It would therefore not be worth while to fight with him over the feeding as he would probably be more at ease if he could feed himself as well as wash himself and do as many things for himself as possible while in bed. Dr. Smith explained that nursing was different from taking care of an infant. He further said that as soon as the fever was down Johnny could be allowed to play quietly in bed and read. The doctor had notified the visiting nurse of Johnny's illness. She in turn was to inform the visiting teacher who would be around to help Johnny keep up with his school work as soon as he felt up to it. The doctor returned two days later and discussed the same things with Johnny himself and again talked a good deal about radio amateurs, and Johnny seemed quite interested. Johnny was improving now and the doctor said if all went well, he probably could begin doing more things in bed within a week or so.

A few days later, Dr. Smith returned in the evening so that he could meet Mr. Miller. He found the father had several additional questions on his mind about which Dr. Smith could put him at ease and together with the patient and the parents, a program for Johnny's activities was worked out, including school work, radio building, and visiting hours by friends and family. Thus Johnny was well started on the road of treatment and recovery. Within a few months he could gradually get up as there had been no further cardiac involvement and his sedimentation rate had remained normal for several weeks without salicylates. Johnny was able to return to school late in the fall and had no difficulty in keeping up with his grades as he was not allowed any athletic periods yet and the interim teaching at home had been sufficient to keep him abreast of his classmates.

This is an ideal story and I am sorry to say that it is only a story because no such gratifying record has come to my attention or that of anybody known to me, although it could and probably does happen this way. Rarely are circumstances as auspicious as those described. Rare seems to be the family where a chronic illness in a child does not become the focus for all the irrational attitudes and anxieties which can at times govern the activities of any one of us. It is worth while, therefore, to review briefly some of the possible ways in which such an illness becomes part and parcel of family interrelationships.

IF YOU WISH to characterize the life of a four-year-old child, he spends his play activities often with other children but emotionally he is completely dependent on the family group. He is probably in the process of working out his patterns of identification, using primarily parental figures to adopt or imitate attitudes, behavior, and thinking. If

he becomes sick at this stage, he will be deprived of his motor outlet without any capacity to channel his energy into non-physical activities. He will moreover be thrown back to continuous association with his mother, being dependent upon her as if he were again two years or younger. The father has again become somebody who comes around in the evening and who can do little more now than read to him, in contrast to the previous play association and doing things together. Four- and five-year-old playmates are not suitable sick-bed visitors. The danger is that this child will regress almost immediately by half his age and if this enforced regression is long enough, he will fall a good deal behind his chronological development if and when he recovers.

At the age of six, the school has become the most important addition in life experience where the child learns to associate with age mates in purposeful endeavor and under comparative discipline. New opportunities and ability for identification are thus developed through teachers and group leaders. If this child were thrown back to the two-year-old level of being nursed in bed with mother the major, almost continuous associate, he would lose four years of his development and in all likelihood would rebel more intelligently and effectively than might the four-year-old against such infantilization. This age group from six to eight is probably the most vulnerable one in the sense that the ability to adapt to abstract diversional activities is low and the need for group activities is high. At this age, the question of institutionalization versus home care is indeed one that defies truly satisfactory solution. The child will need both parents and the companionship commensurate with his age, and careful consideration must be given as to which may be the preponderant need and the more constructive environment. Only a compromise, not an ideal solution, seems possible.

At ten, the child is usually quite comfortable. The gravity of activities and at times emotional investments have shifted to the school and other youth activities without important socializing demands beyond those of acceptable behavior. At this age constructive use of the illness as an important experience in learning new skills such as handicrafts, reading, and even writing can be accomplished, as already indicated. Institutionalization at this age also is a less traumatic experience than it is two or three years earlier.

The most tragic difficulties often arise if a chronic illness befalls a young adolescent because this is usually the most disturbed period in development under the best of circumstances and any handicap that interferes with group activities is a major problem. The process of emancipation from parental guidance and authority engenders many anxieties to which group identification through group activities is an essential counterpart. In addition to the difficulties in group relationships, youngsters of this age are notoriously self-conscious and extremely sensitive to any physical handicap which too often, even in physically healthy children, becomes an excuse to avoid uncomfortable associations and relationships. Great care must be taken that the patient does not utilize his illness in this regressive manner and the parents' main concern should not be authoritative enforcement of bedrest, but the fostering and encouraging of continued associations with other adolescents and schoolmates because too readily a sick adolescent is neglected and forgotten by his friends.

It must be recognized that being bed-ridden and dependent on others always carries with it the element of infantilization. Depending on his previous adjustment, a child may or may not take readily to such a curb of his activities and privileges. I have sketched briefly what to expect at different age levels. Rarely in our experience has this difficulty been overcome successfully because usually we are dealing with already disturbed families. Overprotective mothers will infantilize their children more than treatment requires to assuage their own neurotic needs. Staying in bed becomes a bone of contention in a struggle for authority on the part of the parents and the child's rebellion against this or other unwelcome parental attitudes. Parents, especial-

ly those who have to bring their children to clinic for brief visits, are often over-impressed with their responsibility and with the risk of allowing the child any activity at all. The parents' need to cope with their own guilt feelings renders them overanxious, irritable, and even more restrictive. Such disturbances will spread to the entire family because anxiety is as infectious as is the streptococcus. Still more pathological is the parent or parents, by no means uncommon, who react to such a blow as illness in a child as if it were punishment or retribution for their own shortcomings. This sometimes leads to ignoring the illness or even rejecting the child as it is a constant stimulus to their guilt-laden conscience. It is unfortunately necessary to report that most of the patients who come to the Osler wards at Johns Hopkins in the late or advanced stages of the disease give evidence of such misguided handling or treatment. This happens also if the child was institutionalized, which in itself is a major difficulty for the family but which again will be handled well or badly depending primarily on the parents' personalities and attitudes.

IN CONCLUSION, I wish first of all to emphasize that rest in bed does not automatically mean rest for the cardiac organ and it is the latter which treatment aims at rather than the former. Laboratory data as well as clinical observations have shown that the state of the organism in terms of psychic and cerebral excitation may influence the heart rate more than does muscular exercise. Restful activity of the heart implies, therefore, emotional equanimity of a reasonable degree which, in the family settings, can only be accomplished with the cooperation and constructive help of the entire family and all others concerned with the care of the patient. Maternal anxiety may be a more important and effective focus for therapy than electrocardiographic or fluoroscopic data. Those in attendance must be aware of the different psychological needs at various ages and this, together with the health and social situation of the family group, should be the determining considerations for or against institutionalization.

While the etiology of rheumatic fever is unknown and while there is no evidence that emotional factors enter into the causation of the disease, there is ample evidence that recurrence and degree of invalidism resulting from the illness are closely connected with disturbances in life adjustment and with emotional upheavals. Good treatment and preventive treatment in particular, therefore, must be aimed at ameliorating emotional and social conflicts within the family as the disease is not a matter of one attack, but is a chronic, acutely recurrent condition. Once the first attack has occurred, prevention of recurrence and prevention of disability constitute the optimum in therapeutic aims. This, I wish to emphasize, I consider to be the doctor's job. He needs the assistance of public health nurses and social agencies but should not simply turn over the problem to social agents without further participation and guidance. Too often the nurse or social worker becomes the police officer who checks up on the doctor's orders, especially in the clinic setting, when physicians fail to take active part in the consideration of the social and emotional problems that arise from the illness. The family will and should look upon the physician for guidance, advice, and decisions if the latter have to be made, if only because otherwise there will always be a residual anxiety that the risks involved in the physical ailment are being neglected. A welcome and important step in this direction is the extension of out-patient services into the home where the clinic physician can truly become the family physician, that is, a person who knows the family and the family's problems and therefore can deal with the family as a unit being affected as it is by a chronic illness.

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# FEDERAL HEALTH AND WELFARE LEGISLATION 81st CONGRESS

By the end of its first session this fall, the 81st Congress will have taken action on a number of health and welfare measures in which nurses and other citizens are vitally interested. By the usual method of procedure bills have been introduced, most of them early in the session, and referred to their appropriate committees, in either Senate or House, wherever the bills have originated. In the Senate the Committee on Public Health and Welfare (Elbert D. Thomas, chairman) with its Subcommittee on Health (James E. Murray, chairman) deals with such bills. In the House, most health and welfare bills go to the Committee on Interstate and Foreign Commerce (Robert Crosser, chairman) and the House Subcommittee on Public Health, Science and Commerce (J. Percy Priest, chairman). The respective committees may hold public hearings and later, in executive session, prepare new bills embodying many of the revisions recommended. If approved by majority vote of the committee or committees concerned, the bill now goes to the floor of the Senate or House for vote.

Among health and welfare bills which have gone through the hopper and have reached or are approaching final action, as of August 25, are:

*S 522—Local Health Units* (PHN, March 1949, p. 159). The Senate Labor and Public Welfare Committee has recommended passage by the Senate, in revised form. The House Committee on Interstate and Foreign Commerce is now considering the companion bill which has been favorably acted upon by its subcommittee.

*S 1411—School health services* (PHN, April, p. 219). The Senate has passed. The House subcommittee has recommended passage to the full House committee which is now considering. The most debated provision in the bill is that for state option in furnishing medical care to school children regardless of economic status.

*S 614—Amendment to the Hill-Burton Hospital and Construction Act.* The amendment would extend the date and liberalize provisions of the act. The Senate has passed. House Committee on Interstate and Foreign Commerce is considering. Favorable action is expected.

*S 2352—Child Care and Research Act* introduced by Senators Pepper, Murray, and Aiken. This embodies the provisions of S 904 (PHN, April, p. 220) and Title VI of S 1679 (PHN, June, p. 351). The Senate Committee on Labor and Public Welfare held hearings on the earlier bills. HR 5835 is the new companion bill in the House.

*S 2317—School construction bill,* with companion bill HR 5718, embodies the best provisions of all other school construction bills previously offered. The Senate committee has reported favorably.

*S 246 and HR 4643—Aid to elementary and secondary schools* (PHN, April, p. 219). Senate has passed; House Education and Labor Committee is trying to reach a compromise on aid to private and parochial schools.

*The Housing Act of 1949* (PHN, July, p. 403) was passed by both Houses, signed by the President, and is now law.

A new bill *HR 6000 amending the Social Security Act* in order to give old age and survivors insurance coverage to the employees of non-profit agencies and to the self-employed (and other provisions) has been favorably reported by the House Ways and Means Committee. (PHN, June, p. 352.)

*S 1453 as amended—Emergency Professional Health Training Act of 1949* (PHN, March, p. 159; May, p. 290; July p. 402)—is now on the Senate calendar for vote, with bipartisan support. The House subcommittee is considering the companion bill HR 5940. The amended bill "to provide grants and scholarships for education in the fields of medicine, osteopathy, dentistry, dental hygiene, public health and nursing" introduced

by Senator Pepper for himself and others was accompanied by Senate Report No. 834 giving the reasons for the amendments to the original S 1453. (The report can be secured from the Clerk of the Senate upon request.)

As amended the bill provides:

1. Payments to educational institutions: medicine and osteopathy, $500 for each student enrolled; dentistry, $400; dental hygiene, $150; university-controlled or college-controlled school of nursing, $200; school of nursing providing training leading to a diploma as professional nurse, $150; school of practical nursing leading to a certificate, $100; public health including hospital administration, $1000. Provision is made for additional amounts to be paid for each student in excess of average past enrollment. The total grant to any institution shall not exceed 40 percent of the cost of instruction.

2. Grants-in-aid for "construction and equipment to assist in the establishment of new schools and in the improvement and expansion of existing facilities (including teaching hospitals and other related facilities and including equipment thereof.)" The bill proposes an appropriation of $5,000,000 for each of the next five years. The grant shall not be in excess of 50 percent of the cost of construction and equipment.

3. Scholarships "only in fields in which there are not enough qualified applicants to fill enrollments in such schools." They are to be awarded "on the basis of ability and the extent to which financial assistance is necessary." Individuals receiving scholarships must begin their training "in or before the first semester which commences after June 30, 1953."

4. Establishes a National Council on Education for Health Professions to consist of the Surgeon General, Commissioner of Education, and 10 members (not otherwise employed by government) appointed by the President, to be leaders in the fields of health, sciences, education or public affairs. Also established are a special advisory and technical committee in each of the fields,—medical, osteopathic, dental, nursing, and public health.

5. Amends the Vocational Education Act of 1946 to include vocational education in practical nursing after approval of a state plan for such training.

Funds under this bill (other than 5 above for practical nurse training) are available to institutions "operated as a public or non-profit institution exempt from Federal income taxation, and if it has been approved or accredited by a recognized body or bodies approved for such purpose by the Surgeon General after he has obtained the advice and recommendation of the Council."

The history of S 1453 is in itself a heartening story of democratic society in action. Stimulated by the President of the United States, in May 1948 some 800 people took part in the National Health Assembly in Washington to assist in working out a 10-year program of national health goals. Lack of qualified personnel was perhaps the greatest single "deficit" noted in the section discussions and, of course, lack of funds for training as well as for salaries. Accordingly promotion of training in the health professions became priority one on the Administration's legislative program.

In December 1948 the Federal Security Administrator held a series of conferences with medical, nursing, and dental educators to find out what was wanted in the way of financial support of professional education. Since the days of the Government's Cadet Nurse Corps program nursing leaders had been deliberating on a philosophy and a program in relation to federal aid to nursing education and committees of the national nursing organizations had worked toward this end. When called to Washington in December, they were ready. The original S 1453 introduced in March 1949 embodied in general the conclusions drawn from these joint discussions and the reports submitted. The general health bills S 1581 and S 1679 also contained proposals for federal assistance for the education and training of professional personnel. Public hearings on a number of health bills began June 6 before the Senate subcommittee. Representing the ANA, Mrs. Eugenia K. Spaulding submitted testimony on the need of nursing education for federal aid. Olwen Davies attended the hearings for NOPHN.

*(Continued on page 510)*

# HEALTH EDUCATION IN TUBERCULOSIS

*An experience in patient education*

WILMA M. MAILANDER

A MAN OR WOMAN who enters a tuberculosis hospital for the first time brings with him preconceived attitudes, fears, and apprehensions which may condition for better or worse the progress of his recovery. Acceptance of the hospital with its routines, technics, and all that it has to offer is an important factor in achieving the mental and emotional poise which is essential to his treatment. The patient needs assistance which will encourage him to accept the strange tedious new life. He needs faith in the treatment which is planned for him and in those who are supervising it. He also needs training in the aseptic procedures developed for his protection and that of others. He needs knowledge of the facts about tuberculosis.

## HOW IT ALL BEGAN

In January 1947 the professional staff of the veterans hospital at Rutland Heights, Massachusetts, a tuberculosis sanatorium, got in touch with the health education service of the Massachusetts Tuberculosis League and the Northern Worcester Public Health Association to discuss the possibility of establishing an overall patient health education program. After a period of preliminary exploration and discussion, the chiefs of the various hospital services, working with the personnel of the tuberculosis associations, evolved a "paper" program for the health education of patients, with the following objectives:

1. To give an understanding of the facts about tuberculosis to patients and to their visitors.

2. To create a favorable attitude on the part of the patient toward his hospitalization; to increase his knowledge of his condition, and his desire to get well

3. To influence patients to cooperate in treatment until given a medical discharge

4. To develop an appreciation by the patient of his part in his own care and in the protection of his family while in the hospital and after discharge.

The anticipated outcomes of the program were:

An improvement in the behavior of patients during hospitalization

A better appreciation on the part of the hospital staff and employed personnel of the importance of education in the therapy of tuberculosis

An understanding by the staff members of their roles in patient education

A basic pattern for a practical and continuing program of patient and visitor education in tuberculosis hospitals

Knowledge regarding the kind of leader-

*Miss Mailander is director of health education at Veterans Hospital, Rutland Heights, Massachusetts.*

ship needed and the time required to administer such a program

Ultimately a reduction in the number of patients who leave the hospital against medical advice

It was soon apparent that a trained person was needed to direct this program. A qualified health education consultant was brought in to organize the program. At the beginning it was assumed that consultant services would be needed for only a few months but at the request of the hospital arrangements were made to extend the scheduled time for the program and to continue the health educator's services. This project was finally taken over by the Veterans Administration and a health educator is now considered a member of the permanent staff.

The health educator was placed directly under the hospital manager so that she might have ready access to all services. This placement proved to be good practice because it was easier to achieve coordinated efforts of the entire hospital staff and this was necessary for the success of the patient education program. No hospital staff becomes education conscious overnight. Some members may be hostile to the idea, some may be indifferent, and some who are interested may refrain from participating because they do not know how to carry out an educational process. Providing staff with methods, means, and the know how of teaching is an important phase of the program.

The program was introduced to the hospital and to the patients by means of a questionnaire. The areas in which the patients needed educational information were then determined and plans were built around these. The lack of precedents required that the project be set up on an experimental basis. It was agreed that educational needs existed in four areas: (1) the admission ward (2) convalescent and treatment wards (3) discharge wards, and (4) the visitors.

### WORKING COMMITTEE ORGANIZED

There were three formally organized committee groups which operated in advisory and working capacities. A general advisory committee, composed of the manager, the clinical director, the chief nurse, and assistant personnel manager, acted as an executive committee. The committee of nurses carried on preliminary observations on patient behavior. A selected group of patients was chosen as an advisory committee to facilitate liaison between patients, staff, and personnel. This patients committee also sponsored a fifteen minute weekly radio program on tuberculosis.

Later other committees were added to assist in the program. The overall advisory committee has remained unchanged. A permanent nurses committee is concerned with materials and methods for carrying out their teaching function. A permanent doctors committee is working on general hospital policies. Patient committees have sprung up on several wards but these now have an overall group which has taken on the functions of the original patient committee which retains for itself only the special job of planning the weekly broadcast.

### NURSES HAVE IMPORTANT ROLE

Many important educational needs can be met by the nurse who is in close contact with the patient and who learns firsthand of his problems. She knows the patient as well as does anyone in the hospital. She can give him much help by teaching and reteaching the aseptic technics. She emphasizes the necessity for adhering to treatment and points out the variations of treatment and progress in his individual case. The nurse must be aware of deviations in behavior that show the need for attention and she should be the one to refer problems to the appropriate sources.

A nurses committee composed of four nurses who represent various services is working as a core group for securing participation in the patient education program. While the committee is too new to list accomplishments, it has studied the nursing contribution in the broad program for patient and visitor education. The outline in use listing topics to be discussed during the admission interview has been brought to the attention of all nurses. Nurses on the treatment wards asked for more information than is given in this outline so that they may have a more complete picture of what is being taught the patient upon

admission. They felt this additional material would help strengthen their part in the education of the patient.

The nurses committee has now completed the first revision of this admission interview outline. This will serve as a teaching guide to be used by all ward charge nurses for guiding those under their supervision. The guide has been approved by both the medical and nursing staffs. The committee now will study the needs in each ward of the hospital and will build up material to meet such needs. The bedrest wards are scheduled first and the special treatment wards later. In this manner the denominators common to all wards can serve as foundations for developing special programs for special needs.

### EDUCATION AT ADMISSION

The admission ward is the focal point in an educational program for patients. Here for the first time most patients come to grips with the problems of a disease which may well alter their life histories.

Education at admission has the challenge of teaching the patient to (1) Accept the restrictions of hospitalization (2) Understand the whys and technics of passive treatment (3) Appreciate the nature of tuberculosis, and (4) Adhere to the aseptic technics.

At present the challenge is being met by three patient-nurse interviews and by lectures held twice weekly by the ward physician for groups. The interviews are aimed at discovering the individual patient's needs. The lectures cover cough control, sputum care, the importance of bedrest, food, and diet, asepsis, sanatorium rules and regulations, and the benefits of uninterrupted hospital care.

### FOLLOW UP IS ESSENTIAL

The patient's needs in the treatment and convalescent wards progress logically from those at admission. Because of the very nature of the treatments success depends upon the use made of individual contact. The doctor-nurse team must accept this responsibility. Both carry on individual education at the patient's bedside. The nurse is part of the team and it is her job to answer questions, to review and to reemphasize as indicated. No generalization will serve all patients as each case is unique. A lack of recognition of the patient as an individual with special problems may and often does precipitate his walking out before completion of his treatment.

To date the ward by ward program has but two features common to all. First is the aforementioned radio program forum time in which a hospital authority answers questions about tuberculosis asked by the patients. The second is a page in the hospital's monthly magazine devoted to health education of the patients. Some wards have limited their formal educational activities to these two features only. Others have periodic lecture discussions with their ward doctors who may use projector film slides, blackboard diagrams, and schematic charts. Worthy of mention is the intimate individual patient-doctor relationship.

Many of the members of the patient committee are elected by their wards to work directly with the ward physician and the charge nurse. The groups provide an excellent device for giving the patients a medium of expression and the opportunity to realize that they have some problems in common. This method also helps them assume to some degree the responsibility for their own treatment.

### PROBLEMS PRIOR TO DISCHARGE

At present a series of four discussions is held by the physician with patients starting two months before discharge These lecture discussions cover the topics of work tolerance—which is of concern in medical rehabilitation—of nutrition, of choice of occupation, and of the various community service agencies which may be helpful to the patient and his family. The nurse interviews the patient when he enters the discharge ward. She discusses the aims and routines of this new ward with him. He learns the reasons for this part of his total treatment and its importance in preparing him for the more strenuous post hospital period. Questions are asked. The patient is encouraged to begin to think for himself and is given certain responsibilities such as making his own bed and caring for linens and laundry according to his current physical condition.

When he enters the discharge or ambulant ward the problem of environment again faces the patient. However, here it is not a problem of adjusting to the hospital but one of readjusting to the independent existence which awaits him outside the hospital. It must be realized that every patient has to some degree learned the life of complete dependence upon others. There is a need to rebuild self-confidence and self-reliance. Vocational counseling, social services, medical rehabilitation, and, unique for veterans, a veterans service advisement are used. All these services are in operation at Rutland Heights. The usual minimum time patients spend in the ambulant wards is four months, ample time to cover the ground thoroughly. A check is made to insure that each prospective dischargee has learned the methods of tuberculosis asepsis and procedure. In addition, a planned review of all the educational aspects which will help him in his post sanatorium life is carried out.

### EDUCATION FOR THE VISITOR

The need for the education of the visitor is as compelling as it is for the patient. Family and friends who visit the patient should understand his disease and its treatment. An adequate comprehension of the sanatorium definition of rest will clarify many things for them. Visitors should realize that they represent the link between the patient's old life and his present existence. They can help him "rest" by giving him an adequate but not alarming picture of home and of family problems. They must consider themselves members of the team which is working for his recovery. It is necessary that the family be taught to respect the patient's new way of life, both during hospitalization and afterwards. They must learn they have a responsibility not only in helping the patient now but in assisting him to remain well after he leaves the hospital. The visitor must be taught also that it is his responsibility as well as the patient's to observe sanatorium regulations and to carry out good health practices at all times.

Showcard exhibits and pamphlet displays in the hospital lobby and in the admission ward dayroom are in use A color film strip of 18 frames telling the story of the visitors' role is being developed. The story is positive in its approach. All new patients are given instructions about the methods for protecting visitors. The personal contact and instruction of visitors by competent personnel are part of the overall program. This program of visitor education is a responsibility of the nurses committee.

### THERE IS MUCH YET TO BE DONE

This is the program as it stands today. It is obvious that no phase, no single area of development may be considered perfect. The accomplishments have been arrived at through trial and error. Every phase of the program is subject to modification as it proves feasible and of merit.

Educational materials for patient education in tuberculosis are limited in scope and variety. Few films on tuberculosis meet the specialized needs of the hospitalized patient. A limited number of slides are usable for doctor-patient group lectures. A few pamphlets tell of rest, of what tuberculosis is, and of the need for precautions. There is a great need for other specialized material. Some of these are now being prepared to answer the most pressing requirements as the program advances.

### CHANGING ATTITUDES

Development and progress of the program has been deliberate and snail like. There has been a marked degree of success in some areas and little or none in others. An evaluation at the present time reveals marked changes in the attitudes of patients, staff, and of other personnel. The progressive attitude of the administrative staff was demonstrated by its original request for a program. This open-mindedness of the hospital administrative staff was the cornerstone upon which the experiment was begun. Several doctors and nurses were willing to contribute to the program from the beginning. Their number has steadily increased. The greater participation reflects its acceptance throughout the hospital. Staff members are now inquiring what is the doctor's function, how might we develop the nurse's role, what can the patient do for himself.

When the program was begun, hostility was manifested in several instances by patient groups. Today one of the most progressive groups in the hospital is the patient body. The reversal of attitude bears out the theory upon which the program was developed, that it is not what is being presented for acceptance but rather how the presentation is made that determines success or failure.

The basic pattern for the program as listed in the anticipated outcomes has been established. However, the number of patients who leave the hospital "against medical advice" has not been reduced within the almost two years that the program has been operating. A statistically measurable improvement in irregular discharges still remains an anticipated outcome. Attitudes have changed and we hope will continue to do so. The statistical reflection must eventually bear out what is now only detectable in individual situations.

The value of this program to individual patients is overshadowed by its influence upon the thinking of the medical and nursing staff and indeed upon that of every member of the hospital community. As individual physicians and nurses have considered their role as educators and have reexamined their contributions and functions, there has been a reorientation in attitudes which has helped the hospital to function as an organism in which each part of the whole has a contribution to make. Education has been reestablished as an essential part of the therapy of tuberculosis.

## Fiftieth Anniversary Conference —ICN

*(Continued from page 481)*

of estimating nursing needs and resources, evaluating standards of service, and recommending measures to improve service. Miss Yvonne Hensch of Switzerland, reporting for the Relief Committee, urged that nurses of the world continue to send relief, through the ICN office, to nurses of fourteen countries and nurses as displaced persons in many lands.

I said earlier that the program was a fine blending of professional and cultural interests. There were impressive church services on Sunday; a remarkably beautiful chronicle play "History of Nursing in Northern Countries" written by a Swedish nurse and acted by local nurses, midwives, and doctors—all speaking excellent English; and a beautiful concert by a boy choir in the National Museum. One afternoon was devoted to visits to local health and welfare agencies in Stockholm and one day to visits to country towns near Stockholm to gain understanding of the country and the customs of the people. Think of the organizing skill that went into dividing 4,000 people into groups of 500 each, arranging transportation, visits to places of historic as well as professional interest, and hospitable feasts of welcome at each place!

Last, as the fitting climax, was a visit on the final evening to the world's famous City Hall of Stockholm and to the park at Skansen where replicas of early cottages, churches, and mansion houses formed an appropriate setting for farewells expressed through folk dances, the nurse's choir, and a gracious speech by Miss Hojer.

I am sure that each one of us, as we came away, realized that each country must solve its own problems in its own way, but that the problems themselves are similar everywhere. What such an international conference gives us is a broader horizon and deeper interest. We gain new confidence in nursing as a service of great human value in every land. We make new friends and extend our avenues of communication to them. We get renewed faith, courage, and determination to see our goals clearly, to make adaptations, and to overcome obstacles. At the next meeting of the International Council of Nurses in Brazil four years hence, there will be opportunity to measure the effect of this conference. I feel sure we shall see that nursing progress has been made toward better health of all peoples and toward the peace of the world.

# PROGRAMS OF STUDY

## For the Preparation of Public Health Nurses

Thirty-three of the thirty-eight educational institutions listed below offer to graduate nurses programs of study in public health nursing leading to a degree. While the objectives are different, with resulting variations in admission requirements, length, and content, all programs meet the essential requirements of the National Organization for Public Health Nursing in theoretical and practical instruction, and are approved by the National Nursing Accrediting Service.

The five institutions which offer a basic professional curriculum leading to a degree prepare their students for professional practice in public health nursing as well as other fields of nursing. The graduates of these degree programs are qualified for staff level public health nursing positions under direct nursing supervision.

For further information, write directly to the person whose name is listed under each institution.

**California**

University of California, School of Nursing, Berkeley 4. Margaret A. Tracy, Dean.

University of California, Department of Nursing, 405 Hilgard Avenue, Los Angeles 24. Lulu K. Wolf, Chairman, Department of Nursing.

**Colorado**

University of Colorado, School of Nursing, Boulder. Mrs. Pearl Parvin Coulter, Director of Public Health Nursing.

**District of Columbia**

The Catholic University of America, School of Nursing Education, Washington 17. Janet F. Walker, Director, Division of Public Health Nursing.

**Illinois**

Loyola University, School of Nursing, 820 N. Michigan Avenue, Chicago 11. Chairman, Department of Public Health Nursing.

University of Chicago, Division of the Social Sciences, 5733 University Avenue, Chicago 37. Mary M. Dunlap, Associate Professor, Nursing Education.

**Indiana**

Indiana University, Division of Nursing Education, School of Education, Bloomington. Eugenia K. Spalding, Director.

**Massachusetts**

Simmons College, School of Nursing, 300 The Fenway, Boston 15. Marjory Stimson, Professor of Public Health Nursing.

**Michigan**

University of Michigan, School of Public Health, Ann Arbor. Ella E. McNeil, Professor of Public Health Nursing.

Wayne University, College of Nursing, Detroit 1. Katharine Faville, Dean.

**Minnesota**

University of Minnesota, School of Public Health. Minneapolis 14. Margaret S. Taylor, Director, Course in Public Health Nursing.

**Missouri**

St. Louis University, School of Nursing, 1325 South Grand Boulevard, St. Louis 4. Helen E. Kinney, Director, Division of Public Health Nursing.

**New Jersey**

Seton Hall College, School of Nursing Education, 40 Clinton Street, Newark 2. Caroline di Donato, Director, School of Nursing Education.

**New York**

Columbia University, Teachers College, Division of Nursing Education, 525 West 120th Street, New York 27. Lillian A. Hudson, Professor of Nursing Education.

New York University, School of Education, Washington Square East, New York 3. Amy M. Erickson, Director of Programs in Public Health Nursing.

St. John's University, School of Nursing Education, 303 Washington Street, Brooklyn 1. Mary C. Mulvany, Dean.
Syracuse University, College of Medicine, Syracuse 10. Ruth E. Telinde, Director, Department of Public Health Nursing.
University of Buffalo, School of Nursing, 25 Niagara Square, Buffalo 2. Elizabeth M. Hanson, Administrator of the Public Health Nursing Program.

**North Carolina**
University of North Carolina, School of Public Health, Department of Public Health Nursing, Chapel Hill. Ruth W. Hay, Professor of Public Health Nursing.

**Ohio**
Western Reserve University, Frances Payne Bolton School of Nursing, 2063 Adelbert Road, Cleveland 6. Ellen L. Buell, Director, Programs of Public Health Nursing.

**Oregon**
University of Oregon Medical School, Department of Nursing, 3181 S. W. Marquam Hill Road, Portland 1. Eleanor Palmquist, Course Director in Public Health Nursing.

**Pennsylvania**
Duquesne University, School of Nursing, Pittsburgh 19. Ruth D. Johnson, Dean.
University of Pennsylvania, Department of Nursing Education, 3810 Walnut Street, Philadelphia 4. Adaline Chase, Assistant Professor in Public Health Nursing.
University of Pittsburgh, School of Nursing, Cathedral of Learning, Pittsburgh 13. Dr. Dorothy Rood, Chairman, Department of Public Health Nursing.

**Puerto Rico**
University of Puerto Rico, School of Tropical Medicine, San Juan. Celia Guzman, Assistant Professor of Public Health Nursing.

**Tennessee**
George Peabody College for Teachers, Nashville 4. Edna Lewis, Professor of Public Health Nursing.
Vanderbilt University, School of Nursing, Nashville 4. Helen M. Howell, Associate Professor of Public Health Nursing.

**Territory of Hawaii**
University of Hawaii, Department of Nursing, Honolulu 10. Virginia A. Jones, Associate Professor of Public Health Nursing.

**Texas**
Incarnate Word College, San Antonio. Sister Charles Marie, Director of Nursing Education.

**Virginia**
Medical College of Virginia, Department of Public Health Nursing, 1222 East Marshall Street, Richmond 19. Two programs of study in public health nursing; one for white students, Medical College of Virginia School of Nursing; one for Negro students, St. Philip School of Nursing. C. Viola Hahn, Director, Department of Public Health Nursing.

**Washington**
University of Washington, School of Nursing, Seattle 5. Kathleen M. Leahy, Director, Program of Study in Public Health Nursing.

**Wisconsin**
Marquette University, College of Nursing, 3058 North 51st Street, Milwaukee 10. Anna Hassels, Director, Program of Study in Public Health Nursing.
University of Wisconsin, School of Nursing, 1402 University Avenue, Madison 6. Martha R. Jenny, Associate Professor of Public Health Nursing.

The following basic professional curricula have been approved for public health nursing:

**Connecticut**
Yale University, School of Nursing, New Haven. Elizabeth S. Bixler, Dean, School of Nursing.

**New York**
Cornell University-New York Hospital School of Nursing, 525 East 68th Street, New York 21. Virginia M. Dunbar, Dean.
Skidmore College, Department of Nursing (New York University-Bellevue Medical Center-University Hospital), 303 East 20th Street, New York 3. Agnes Gelinas, Chairman, Department of Nursing.

**Tennessee**
Vanderbilt University, School of Nursing, Nashville 4. Julia Hereford, Dean, School of Nursing.

**Washington**
University of Washington, School of Nursing. Mrs. Elizabeth S. Soule, Dean, School of Nursing.

# TRENDS IN MEDICINE AND PUBLIC HEALTH

## HUNGER AND HUMAN BEHAVIOR

Physiologic and psychologic changes in man as a result of prolonged starvation have been studied by a number of workers in recent years due to the widespread famine conditions throughout the world. One such study, by Franklin Schiele, Brozek, and Keys, was reported in the *Journal of Clinical Psychology*, April 1948.

The experiment was begun in 1944 at the University of Minnesota. Its purpose was to determine the relative effectiveness of different types of diet in bringing about rehabilitation. Thirty-six young men between the ages of 20 and 33 years were recruited and screened for physical and mental suitability were later dropped for deviating from the diet. Control observations were made during three months, in which the subjects were maintained on a "good" diet (3492 calories per day). Six months of semistarvation followed in which the intake was reduced to an average of 1570 calories. The diet was planned to simulate that available in Western and Central Europe during the war, and was calculated to produce a weight loss of about 25 percent. Three months rehabilitation followed, in which the men were divided into four groups, receiving additional allotments of approximately 0, 400, 800, and 1200 calories.

At the end of the semistarvation period, the average weight loss was 24 percent, with some of the actual body weight loss being masked by accumulation of edematous fluid, especially in the ankles, knees, and face. The subjects reported that their nails grew more slowly, their hair was falling out in greater quantities, and wounds, such as shaving cuts, healed more slowly. Tolerance to heat increased,—food was required unusually hot and during the summer the subjects slept under blankets and wore extra clothing. Objective tests revealed no decrease in visual acuity, but there were complaints of inability to focus, eye aches, and seeing "spots." Overt movements became noticeably slower, and voluntary energy output was considerably reduced. The symptoms were in the pattern of experience characteristic of aging. Anticipation of eating heightened the craving for food, their attitude toward it becoming very possessive. Conversation was at a minimum while eating. Many attempts were made to make the food appear to go further, and large quantities of coffee and tea were employed even by those who had previously not used them. Chewing gum and smoking were employed heavily, both in degree and in numbers of participants. Food in all its ramifications became the chief topic of conversation, reading, daydreams.

The prolonged strain upon the subjects was reflected in increased emotional instability. Tendencies toward depression, hysteria, and hypochondriasis were markedly increased. Of the three, depression seemed most pronounced. The men were more serious and obviously less happy. There was a general apathy toward topics which formerly held the subjects' interest, although general intelligence seemed unaffected. The high group morale gradually disappeared, and such humor as remained became of the ironic and sarcastic variety.

During rehabilitation, progress of recovery was slow. At the end of 12 weeks, the subjects in the highest calory group (1200 calories in addition to the basal rehabilitation diet) had regained only 60 percent of the weight loss. Those in the 400 calory group gained no weight during the first six weeks and after 12 weeks had regained only 20 percent of weight lost. Some of the subjects actually lost weight during the early part of

the rehabilitation period, due to disappearance of the edema. Recovery from dizziness, apathy, and lethargy was most rapid, whereas tiredness, weakness, and loss of sex drive were slow to improve. Physical capacity resembling that of the prestarvation state was approached only after six months rehabilitation. At the end of the 12th week of rehabilitation, 20 of the men were permitted absolute freedom in their food intake. The response was immediate, and at 33 and 55 weeks after the end of the starvation period they exceeded their prestarvation weights.

An important feature of this study has far-reaching implications in the socio-political field. At the start of the experiment, the group was characterized by good humor, friendliness, and fellowship; democratic principles and spirit guided them in their actions. As the starvation period proceeded, the men lost some of their ability to make rational decisions; the moral fiber degraded to a point where some stealing of food occurred. Regulations which were at first questioned came to be accepted without challenge; leadership and initiative among the men disappeared completely and they welcomed firm direction. Starvation had made them submissive. These observations point to the importance of proper nutrition in shaping world governments for it is a fact democracy has never existed in a country where there was not enough of food.

## NATIONAL HEALTH COUNCIL

The annual report of the National Health Council, of which NOPHN is one of 23 member agencies, gives a birds-eye view of the gains made during 1948 in accomplishing its objectives—(1) the promotion of full-time local health departments throughout the nation (2) the promotion of local and state health councils (3) cooperation with existing health councils by acting as a clearing house for information (4) recruitment and training of community health personnel and (5) development of ways and means of strengthening the usefulness of the National Health Library. Toward the last two named, only informal and preliminary explorations have been possible while toward objectives one, two, and three there has been unmistakable progress.

Some 40 million U. S. citizens today lack basic public health services, and it has been estimated that no more than 10 percent of the population is served by local health departments or "units" meeting currently recognized standards. At the March 1947 meeting, NHC delegates resolved that the major concern was early extension of local health departments adequate to the needs of all our population. A National Advisory Committee on Local Health Units was established with a membership of 51 national bodies, including NOPHN, of which 28 were concerned with broad civic interests and 23 more specifically with health problems. It is the committee's primary function to stimulate action on the local level. In 1948, regional conferences, the first in Indiana in April and another in Salt Lake City in October, were held in which delegates from the various states of a particular region could come together to determine what their problems were in relation to the health unit in general.

Two more regional conferences on local health units have been held, April 1949 in Kansas City and in Omaha, to give representatives of the states in the Great Plains Area a chance to discuss problems of mutual interest.

The National Advisory Committee on Local Health Units sponsors the Local Health Units Act of 1949, S 522, and members of the committee, including Haven Emerson, the father of the local health units program, presented statements at Senate Committee hearings on the bill in May 1949. The National Congress of Parents and Teachers has made the passage of needed legislation, both federal and state, a major project.

It is through local and state health councils that public health agencies and citizen groups can plan and work together for better community health. Today, there is an ever increasing wave of interest in the health council. There are 400 health councils—those which are newly established and those which are being reactivated. A constant flow of requests now comes to the NHC asking assistance in establishing councils in communities throughout the nation, and there has been no active promotion of the NHC services to achieve this interest. It has been spontaneous.

### HAIR AND SCALP TREATMENTS

Fees equivalent to those of a major surgical operation are paid by thousands of persons each year for futile hair-saving or dandruff-curing remedies, according to a report by the American Medical Association's Committee on Cosmetics which appeared in the March 26, 1949 *Journal of the AMA*.

The Committee asserts (1) there is no proof that temporary increase in blood supply to an area treated by massage postpones the loss of hair or in any other way influences baldness (2) ultraviolet rays have some usefulness only when in the hands of those whose scientific background makes them capable of understanding the limitations and potential health hazards of the ray.

Hair "tonics" simply groom the hair. They are usually simple mixtures of common drugs such as acetic acid, resorcinol compounds, mercuric chloride, sulfur and betanaphthol. Sulfonamide drugs in hair "tonic" has, by intensive clinical and laboratory research, been proved worthless as a cure, and even a serious danger when used indiscriminately. There is no evidence that hormones will influence the growth of hair in ordinary baldness. There is a relationship between hormones and the normal amount and distribution of hair, although its nature has not definitely been established. Vitamins, as used with the hair "tonic," do not influence ordinary baldness, and injections into the scalp can have disastrous results.

Dandruff is a manifestation of a normal physiologic process—flaking off of dead cells. The continuous use of synthetic detergent shampoos, excessive use of irritating hair lotions, overeating of sugars and starches, improper hygiene and poor general health, all have been defined by authorities as aggravating the shedding of dead cells. The only treatment is daily gentle massage followed by brisk brushing of the hair, and frequent shampoos in soft water.

A tendency toward premature baldness is hereditary, and the endocrine glands are known to be an influential factor in normal growth but the relationship is still unsolved.

In the manner of treating baldness, one should consider the question whether or not he is losing more than the average amount of hair, for shedding of hair is a normal process. The average adult hairline does indent over the eyes, replacing the straight hairline of childhood. Medical science does not know of any device, substance or method which will regenerate hair lost in these conditions. It is wise to undergo a thorough physical examination before any diagnosis is completed since the balding condition is generally a result either of constitutional factors or a combination of local and constitutional factors.

## Federal Health and Welfare Legislation

*(Continued from page 500)*

Next step by the Senate committee was to divorce consideration of the educational aid question from other more controversial matters in the general health bills and to present its recommendations in the form of amendments to S 1453 which deal only with this one subject. At the conclusion of the formal hearings the subcommittee requested representatives of the professions and educational institutions concerned, of the hospitals and the Public Health Service to meet with the subcommittee's staff to prepare an acceptable bill. The discussions lasted four days. S 1453 as amended is the result of this long period of study and consultation. Evidence of Senate committee appreciation of and willingness to accept cooperation is expressed in Senator Murray's gracious letter to Olwen Davies:

> I have received and read with care the report on the informal meetings regarding federal aid to education in the health professions in which you participated. It is readily apparent from the report that the understanding, tact, and willingness to give and take displayed by the participants in those meetings have resulted in a distinct contribution of great value to both the United States Senate and the health professions concerned.
>
> I am writing this to convey to you my sincere appreciation of the service you have rendered us. I am sure that when my colleagues have had opportunity to study the report they will share my feeling of gratitude.

# NEW BOOKS
## AND OTHER PUBLICATIONS

### HOSPITAL TRENDS AND DEVELOPMENTS, 1940-1946

Edited by A. C. Bachmeyer and Gerhard Hartman. New York, Commonwealth Fund, 1948. 819 p. $5.50.

This book is a compilation of articles written by leading hospital administrators, doctors, nurses, and board members of hospitals during the period 1940-1946. It gives a sample of literature of this period, a good bibliography, and shows clearly the trends of the time. Trends most clearly emphasized are growing acceptance of the responsibility of the hospital as a part of the community and its need for planning on a community wide basis; emphasis on the auxiliary worker and the need and types of training and supervision; a better understanding of the geriatric patient; the importance of a wider background in sociology and psychology on the part of all workers coming in contact with the patient to meet the need for health teaching. It clearly points the way to a better understanding of functions of such related professions as dietitians and medical social workers.

One of the outstanding features of the book is its emphasis on the increasing science of hospital organization and management with greater recognition of its place and responsibility as an agency not only for service but as a laboratory for all professional teaching. The implications for nursing education are many and suggest that there will be strong support for advancing nursing education.

In the section on nursing service are definite recommendations for reducing the number of nursing schools; for preliminary study of from one to two years of general education on a college level for entrance to the school of nursing; more men students; and for additional schools for vocational nursing. These trends seem to have laid the foundation for the Brown Report. Another important implication is the great need for better integration of public health nursing and community responsibility for the student.

It is interesting to note that health teaching and the need for all health groups to work together is emphasized, not in the old sense, but in a new concept which appears to be forming in which all members of the group participate in planning rather than the old concept of a hierarchy receiving orders from the top.

A criticism might be that the book does not have adequate coverage regarding the public health integration of hospital and community for the preparation of the nurse in total patient care. However, it gives an excellent background and resource for the present plan of teaching nursing, where we are thinking of the better school, fewer schools, students prepared not just for hospital service but for the type of work they are going to meet out in the community.

—ELIZABETH S. SOULE, R.N., *Dean, School of Nursing, University of Washington, Seattle, Washington.*

### SAFEGUARDING MOTHERHOOD

By Sol T. De Lee. Philadelphia, J. B. Lippincott, 1949. 135 p. $2.00.

The author, a nephew of the famous Dr. Joseph B. De Lee, presents a thoughtful, clinical approach to motherhood.

The book is written simply, clearly, and unemotionally, as if the doctor were talking to a patient and her husband. It anticipates their questions and answers them concisely and adequately. However, the explanations become too involved with unusual occurrences rather than with the natural, healthy functioning of the normal woman, to meet the need of the average individual. Too much time is devoted to the caloric values of foods rather than nutritive values. Medical groups will probably disagree with the general recom-

mendation of sodium bicarbonate and mineral oil for common disorders during pregnancy. The illustrations are highly technical and better suited to a medical text. The addition of a glossary of unfamiliar words to preserve the correct terminology in the text is commendable.

—MARION STRACHAN, R.N., *Instructor in Nurse-Midwifery, Maternity Center Association, Berwind Branch, N. Y.*

### OVERWEIGHT IS CURABLE

By Winifred Dorfman and Doris Johnson. New York, Macmillan, 1948. 160 p. $2.75.

This is an excellent treatment of the subject for the layman. It presents causes, effects and treatments of overweight in a very understandable fashion. While giving attention to such influences as heredity, glandular secretions, and the emotions the authors emphasize the fact that the fundamental cause of overweight is over-consumption of food.

The discussion of the effects of overweight should convince the most skeptical of the importance of weight reduction and serve to fortify the will power.

The dietary treatment includes a brief review of the requirements of an adequate diet and shows how the low calorie diet is an adaptation of the normal. This approach has the advantage of establishing new food habits in the patient as well as producing weight loss.

The food composition and calorie tables that have been included should be very helpful to the subject who wishes to plan intelligently for weight reduction.

—MAY S. REYNOLDS, *Professor of Home Economics, University of Wisconsin.*

### HOW TO LIVE LONGER

By Justus J. Schifferes. New York, E. P. Dutton, 1949. 255 p. $3.00.

According to the author, approximately 250,000 of the persons who are killed yearly by one or another of the ten leading causes of death, dies unnecessarily—a victim of involuntary suicide. It is the intent of this book "to correct some of the ignorance, allay some of the fears, and challenge some of the stodgy indifference" that contribute to this unnecessary waste of life.

The layman will find this discussion of the ten big killers and what can be done about them not only informative but also readable. Those working in the health field will find it a useful reference.

—L. MAURINE PETERSON, *Health Education Consultant, Department of Public Health, Boise, Idaho.*

### WARD MANAGEMENT AND TEACHING

By Jean Barrett. New York, D. Appleton Century, 1949. 400 p. $4.00.

This book should prove extremely helpful to all head nurses, even though it is designed primarily as a text for nurses who are preparing themselves for positions as hospital head nurses. It contains many practical and authentic answers to perplexing problems that head nurses daily meet.

The book is well planned and the text is presented in a concise, interesting, and exceedingly readable manner. It is skillfully arranged in divisions which deal specifically with the head nurse as a person, her relationship to the patients, and her full responsibilities and place in the total hospital scheme.

The outstanding feature of this book is the clearness and directness with which the author defines the place and responsibility of the head nurse in providing the type of nursing care which extends beyond the environment of the hospital and embodies full knowledge and awareness of social, economic, and family relationships. This book should give encouragement and status to the often overlooked and over-worked head nurse because the strategic and important position of the head nurse in the administration of "quality" nursing care for patients, as well as the provision of a rich field for the learning of nursing by student nurses, is treated in detail.

The author has provided many learning aids in the book. At the end of each chapter problems are suggested for discussion and up-to-date and complete references are provided for further study. This book should be on the shelf of every head nurse.

—LORETTA E. HEIDGERKEN, *R.N., Ed.D., Assistant Professor of Nursing Education, Catholic University, Washington, D.C.*

### DIABETIC MENUS, MEALS AND RECIPES

By Betty M. West. New York, Doubleday and Company, 1949. 254 p. $2.95.

This is a good book for a reference library. It would also be valuable to diabetic patients who wish to elaborate upon their diet and make it varied. However, I do not consider it a very practical book for public health nurses because in our nutrition education we try to emphasize simplicity in all therapeutic diets so that the average person with whom the public health nurse comes in contact would be able to follow directions. The present trend in teaching diabetic diets to the lay person is to avoid the use of terms such as grams of protein, fat, and carbohydrate and to teach them a normal adequate diet in the terms of household measures and normal size servings of food giving them a few substitutes for variety. We do not advocate the use of mineral oil salad dressings. Most diabetics are able to have small quantities of fat in their diet and this will allow reasonable quantities of salad dressing if desired.

The table of approximate food values is excellent reference material for use by the public health nurse. The supplemental table also carries good information for anyone helping to instruct diabetic patients if they wish to vary their diets.

—Kathryn W. Heitshu, *Director of Dietetics, Medical College of Virginia, Richmond, Va.*

### MATERNITY CARE

Prenatal Care. 76 p. 1949, Pub. No. 4. Federal Security Agency, Children's Bureau, Washington 25, D. C. 15c.

This new edition has been broadened in order to supplement the advice doctors give expectant mothers and fathers. Medical drawings of the embryo and the fetus at various stages help to explain the physical changes in pregnancy. Morning sickness, RH factor, premature birth, and blood tests are a few of the many things discussed informally in the booklet. Single copies are available to parents and professional workers without charge from the Children's Bureau. Copies may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 15c each, with 25% discount on 100 or more copies.

### MEDICAL ECONOMICS

Perspectives in Medicine—The March of Medicine, 1948. No. 13 of the New York Academy of Medicine Lectures to the Laity. N. Y., Columbia University Press. 1949. 163 p. $2.50.

### MENTAL HEALTH

Human Relationships in Public Health. Report of an Institute on Mental Health in Public Health. By Geddes Smith. The Commonwealth Fund, N. Y. 1949. 18 p. Single copies 15c.

This report contains many helpful clues to better interpersonal relationships for all health workers.

Psychiatry For Nurses. By Louis J. Karnosh and Dorothy Mereness. 3rd ed. St. Louis, C. V. Mosby. 1949. 437 p. $4.00.

### NURSING EDUCATION

Nursing Resources and Needs in Minnesota. By the Subcommittee on Aid of the Governor's Advisory Committee on Nursing. University of Minnesota Hospitals, Minneapolis. 141 p. 1949.

### ORTHOPEDICS

Integration of Principles of Body Mechanics and Posture in Nursing. By Margaret C. Winters. American Physical Therapy Association, 1790 Broadway, New York. 6 p. 10c.

Excellent reference for nurses and physical therapists concerned with and participating in staff educational programs, schools of nursing, and clinical experience.

### POLIOMYELITIS

Poliomyelitis. Compiled and edited for the International Poliomyelitis Congress by the National Foundation for Infantile Paralysis. Philadelphia, J. B. Lippincott. 1949. 360 p. $5.00.

The proceedings of the conference in New York City, July 12-17, 1948.

Polio Can Be Conquered. By Alton E. Blakeslee. 31 p. No. 150. 1949. 20c. Public Affairs Committee, Inc., 22 East 38 Street, New York 15, N. Y

### PSYCHOLOGY

Psychology For The Profession of Nursing By Jenne G. Gilbert and Robert D. Weitz. New York, The Ronald Press. 1949. 275 p. $5.00.

### RECORDS AND REPORTS

Handbook on Statistical Recording and Reporting in Family Service Agencies. By Anne W. Shyne and Helen I. Fisk. New York, Family Service Association of America. 1948. 84 p. $2.25.

# FROM NOPHN HEADQUARTERS

## REGIONAL CONFERENCES

Two NOPHN regional meetings are planned for early December to be held in Richmond, Virginia, and Indianapolis, Indiana. In the spring of 1950, immediately preceding the biennial convention, the NOPHN hopes to have a similar kind of meeting on the west coast.

The meetings are planned to meet the many requests from member agencies and individual members. Assistance will be given by local planning groups which are being organized. In Richmond, Abbie I. Watson, the executive director of the Instructive Visiting Association, is chairman. Marie Winkler, assistant director of the Visiting Nurse Association in Indianapolis, is chairman of the planning group in that city.

Sessions will take place as follows:

Richmond, Virginia: December 6-7, 1949, John Marshall Hotel
Indianapolis, Indiana: December 13-14, 1949, Severin Hotel
Sessions will be held from 9:30 am. to 4:30 p.m.
Registration fee: $2 for 1 day
$4 for 2 days

The program for the first day will be planned for two groups. The first is a school nursing conference and is open to all interested public health nurses. This conference will be conducted by the officers and staff of the NOPHN School Nursing Section.

The second group will be restricted to an invited list of directors of public health nursing agencies and directors of programs of study in public health nursing. At this conference there will be a discussion of mutual problems.

The general meeting of the second morning will be open to all. The program is to be announced. On the afternoon of the second day special interest discussion groups will be arranged, groups such as board members, supervisors, staff nurses. The NOPHN will welcome suggestions concerning other interest groups so plans can be made for them also.

An application for advance registration will be found on page A7. Other registration blanks are available upon request. We earnestly ask that you send questions or suggestions about problems you would like to have discussed at these meetings.

## MENTAL HYGIENE CONFERENCE

Ruth von Bergen, administrative director of the Conference on Mental Hygiene Education in Public Health Nursing, spent the week of July 25th at NOPHN offices. She worked with members of the staff and with Esther Garrison of the National Institute of Mental Health on preliminary plans for the conference which will be held in New York City November 14-18, 1949. Miss von Bergen also met with Dr. Kenneth F. Herrold who is consultant on group methods for the conference. Dr. Herrold, assistant professor of education at Teachers College, is well known in the field of group development. Among his many responsibilities he is consultant to the White House Conference on Children and Youth.

## TWO VNA's IN NEW QUARTERS

Two member agencies of NOPHN have moved into spacious new headquarters. Gammell House, for many years the home of Mrs. Robert Ives Gammell, was given to the Providence (R.I.) Visiting Nurse Association by her daughter, Mrs. Gammell Cross, a vice president of PDNA and a member of the NOPHN Board. The growth of the nursing service makes these new larger quarters eminently desirable. Three stories allow for administrative offices, classrooms, and reception rooms. There is ample space for meetings of various sizes.

The new home of the Visiting Nurse Association of Rochester, New York, writes Elizabeth C. Phillips, executive director, was made possible by a bequest from Mrs. Edith H.

New homes for Providence District Nursing Association (left) and Visiting Nurse Association of Rochester (right).

Babcock. All service, educational, and administrative activities, including those of its five districts take place under one roof. The staff, students, and volunteers coming in each day number close to 100. Among distinctive features of the building are a little library, a demonstration room permanently set up as a home kitchen and bedroom with a real bathroom adjoining, a large assembly room, and a small room which the faithful volunteers may call their own.

### RESEARCH STUDIES

Beginning with this issue (see page 477), PUBLIC HEALTH NURSING will publish at intervals information about studies in public health nursing service and public health nursing education carried out by nurses in colleges and universities in the United States. The *American Journal of Nursing* will feature data about studies in nursing service and nursing education (See September issue for first reports). Inquiries for other details about any of the studies should be directed to the college or university, not to headquarters!

### POLIO EPIDEMIC WORK

The incidence of poliomyelitis increased rapidly in the state of Arkansas in July and JONAS staff was invited to Little Rock to evaluate nursing needs.

Many of the nurses from Arkansas and 20 other states who volunteered for epidemic work had not had preparation or experience in the care of the polio patient. The National Foundation for Infantile Paralysis approved the request for a special grant to finance an in-service training center. One hundred and thirty nurses have received preparation and supervised experience at the in-service training center established at the University Hospital of Arkansas. Louise Suchomel and Lucy Blair, NOPHN consultants on JONAS, assisted in establishing the training center, helped plan a teaching program which could be carried on while service needs were being met, and remained to carry on the instruction until qualified instructors and supervisors could be secured. Such training centers will be established in other areas if needed.

JONAS staff participated in polio epidemic work in Arkansas, Oklahoma, and Texas during July. Help was also given in 12 states to prepare nurses to give better care to polio patients of 1949.

### NOPHN STAFF MEMBERS

Marion P. Kerr came to headquarters on August 1st as orthopedic nursing consultant with the Joint Orthopedic Nursing Advisory Service. Miss Kerr has a bachelor of science degree from the University of Pennsylvania, and is a graduate of the Paterson General Hospital, Paterson, New Jersey. She has had study at the American College of Physical Education in Chicago, the Children's Rehabilitation Institute in Maryland, and is a graduate of Harvard Medical School, Physical Therapy. Miss Kerr has had varied nursing experience. She was orthopedic intern with the Boston

VNA and has been on the staff of the Brooklyn VNA, where her last position was that of orthopedic supervisor. Recently Miss Kerr was part-time instructor in nursing education at the University of Pennsylvania. She has contributed a chapter on the role of the public health nurse to a book by Dr. and Mrs. Knocke on orthopedic nursing which will be published shortly by F. A. Davis.

Jeannette Johnson, who had a special 6-month assignment to the JONAS staff, left July 31st. Mrs. Johnson expects to establish a home in Denver.

### NOPHN COST STUDY

The Cost Study project continues busily. The staff has been temporarily augmented to help with the computation of the figures sent by the agencies participating in the study. Four young students, majors in mathematics and other fields, are spending their vacations at 1790 helping out. One thing is certain, they know more about public health nursing than any other college math majors anywhere in the world. And they like public health nursing!

### NOPHN FIELD SCHEDULE

| *Staff Member* | *Place and Date* |
|---|---|
| Ruth Fisher | Utica, N. Y.<br>Columbus, Ohio |
| Dorothy Rusby | Columbus, Ohio—Sept. 7-16 |
| Jean South | Washington, D. C.—Sept. 9-10<br>New Britain, Conn.—Sept. 29 |

July and August field trips not previously announced included: Anna Fillmore—Pittsburgh, Pa.; Mary T. Collins—Chicago, Ill., and Harrisburg, Pa.; Lucy Blair—Arkansas and Oklahoma; Louise M. Suchomel—Arkansas, Texas, and Des Moines, Iowa; and Marion Kerr—Des Moines, Iowa.

## ABOUT PEOPLE WE KNOW

Reorganization of the Bureau of Medical Services and the Bureau of State Services in the USPHS has been under way for some time. New divisions in BSS are: Chronic diseases, headed by *Dr. A. L. Chapman,* and dental public health, by *Dr. J. K. Knutson.* New divisions in BMS include: Nursing resources, headed by *Margaret Arnstein,* medical and hospital resources, *Dr. John R. McGibony,* and dental resources. . . *Sister M. Olivia Gowan,* Dean of the School of Nursing Education, Catholic University of America, received an honorary LLD from Boston College in June. Sister Olivia is a member of the NOPHN Education Committee. . . *Sylvia Bryson* is the new director, division of public health nursing, Seattle-King County Department of Public Health. . . . *Julia Dupuy Smith* has accepted an appointment at the University of Michigan as resident lecturer in the School of Public Health and School of Nursing. . . *Iva Torrens* has joined the Central Office staff of the Veterans Administration Nursing Service. . . *Pearl Kamerer* has retired as director of the Utica VNA after 24 active years. She is succeeded by *Marcetta Horn.* . . A new public health nursing program has been initiated at the Boston University School of Nursing. To administer this program, *Anna C. Gring* has been made chairman of the School of Nursing, Public Health Nursing Department and associate professor of nursing. She will be aided by *Geraldine Hiller* newly appointed assistant professor of nursing. . . *Olive Baggallay* of England has been appointed first nurse consultant on the WHO staff in Geneva. She will be the nurse consultant to the public health administration section of the Department of Operations, and will be staff planner and advisor in developing nurse training programs. *Lyle M. Creelman* has been appointed nursing consultant in maternal and child health with WHO. Previous to this appointment, Miss Creelman held important administrative positions in the public health field in Canada and was on the UNRRA staff. Just recently she completed an extensive study of public health nursing practices in Canada. . . *Mrs. Anna Taylor Howard* has resigned as associate editor of the *American Journal of Nursing. Esther Brooks* joined AJN as assistant editor as of July 18.

# NEWS AND VIEWS

## SCHOOL DATA RETURNS SET RECORD

A 96 percent return of the questionnaires on nursing education facilities sets a new record in cooperation with a national committee. The questionnaires were sent to all schools of nursing in the United States, Hawaii, and Puerto Rico. Special credit is due members of the nursing, hospital, educational, and allied professions—especially the state leagues and state boards—who help to stimulate schools to participate in the survey.

The Subcommittee on School Data Analysis, a subcommittee of the National Committee for the Improvement of Nursing Services, reports gratifying results in the analysis of the school data voluntarily submitted by the schools. It was stated to schools at the beginning of the survey, that one of the outcomes would be a classification of the nation's basic programs in nursing. Such a classification would be only an interim screening of the schools. It would serve only until the National Nursing Accrediting Service has been in operation long enough to have evaluated a larger proportion of schools than at present.

The classification, as a preliminary and interim screening, will assist the national and state committees on careers in nursing to guide prospective students to schools best suited to their capacities. It will also help the schools to identify their program needs in light of the school profiles. These will be sent only to the individual schools.

The NCINS and its subcommittee have been working on school data analysis recommendations for a classification which is being presented to the boards of the six national nursing organizations. The information secured by the survey will be useful to regional groups planning for the improvement of nursing services.

Articles on the School Data Analysis are scheduled for publication in fall issues of *American Journal of Nursing*.

## ACCREDITING SERVICE

The Public Health Service Federal Security Agency has released Mary J. Dunn, senior nurse officer, for a limited period to the National Nursing Accrediting Service. Miss Dunn, who is chairman of the Joint Committee on Integration of Social and Health Aspects of Nursing, and a member of the NOPHN Education Committee, will act as secretary to the Board of Review for Public Health Nursing of the NNAS.

## VNSNY WILL ENTERTAIN ALUMNAE

On Wednesday, October 26, from 4:30 to 6:00 p.m., the Visiting Nurse Service of New York City (formerly the Henry Street Visiting Nurse Service) will serve tea to all alumnae at its headquarters, 262 Madison Avenue.

## NURSING LEADER LEAVES

The resignation of Blanche Pfefferkorn, director, Department of Studies, NLNE, became effective September 1.

Widely known as an authority on nursing education and nursing service, Miss Pfefferkorn has for almost 25 years occupied a position of authority and trust at national headquarters. Her broad knowledge of nursing affairs and wise counsel will be greatly missed.

## ELIZABETH C. BURGESS

Nurses all over the world will be saddened to learn of the death of Elizabeth Burgess in New York on July 21st. Miss Burgess for a long time was influential in promoting standards of nursing education. At the time of her death she was professor emeritus of nursing at Teachers College, Columbia University, where she had been on the faculty for 25 years. Throughout her career, since her graduation from the Roosevelt Hospital School of Nursing in New York in 1904, Miss Burgess was active in national nursing organizations. She was especially interested in the advancement

of nursing education through legislation, and lectured and wrote on this subject. Miss Burgess was a member of the NOPHN Committee on Accreditation. With her death nursing loses another stalwart leader.

### SUSAN KIESS HONORED

The first gold medal awarded by the Pennsylvania SNA for distinguished service to nursing was won by Susan E. Kiess. This award is the first of its kind to be made in this country, and it will be given annually by the Association to the nurse whose achievements have distinguished her during the preceding year.

Miss Kiess, supervisor Lycoming and Tioga Counties, State Department of Health, was selected for the award for her outstanding work encouraging and organizing nutrition programs in schools, as well as developing child health centers. She also interested various civic organizations in contributing funds to finance remedial work for the children and for equipment for the centers.

In her acceptance of the medal, Miss Kiess acknowledged the award in the name of her nine staff nurses "each one of whom had an integral part in the work."

● Stipends are now available from the Public Health Service for university training of qualified public health nurses as mental hygiene consultants, under the National Mental Health Act. These are $1,600, $2,000, $2,400 per year, depending upon the preparation and experience of the applicant.

Applicants should have graduated from an accredited school of nursing, be registered in at least one state, have a B.A. or B.S. from a recognized college or university and an approved program of study in public health nursing, and give evidence of a satisfactory supervisory experience some of which should have been in a generalized public health nursing agency.

Courses are given at Catholic University of America, Columbia University-Teachers College, Johns Hopkins University, and the Universities of Minnesota, Pittsburgh, and Washington.

Applicant should address the institution of his choice. If the application is accepted the institution will recommend to the Surgeon General that a stipend be awarded. Upon final approval payment is made to the student directly by the institution where he will take his training.

● The National Blood Program of the ARC offers expanding employment opportunities for nurses who can fill chief nurse and deputy chief nurse positions in blood centers. A college degree or at least two years of college work is required, as well as experience in public health nursing, teaching, and administration. Blood bank or operating room experience is desirable but not required. There are also other excellent employment opportunities in ARC for nurses qualified in the field of public health and health education. Inquiries should be directed to Norman A. Durfee, Administrator for Personnel Services, National Headquarters, American National Red Cross, Washington, D. C.

● The Departments of Nursing Education and Public Health Nursing, Syracuse University, in cooperation with the New York State Department of Health and Triboro Hospital, now offer courses in tuberculosis nursing for graduate nurses. For public health nurses an advanced program leading to a Master of Science degree with the purpose of preparing the public health nurse to assume major responsibility for the tuberculosis nursing service in a community public health program is available, as well as supplemental courses acceptable toward a Baccalaureate degree in public health nursing. The program will begin this fall. For further details write Ruth E. TeLinde, director, Department of Public Health Nursing, College of Medicine, Syracuse University, Syracuse, New York.

● Dalhousie University School of Nursing in Halifax, Canada announces a five-year basic program in nursing and also a one-year program for graduate nurses. The one-year course of study may be taken for a diploma in public health nursing or in teaching in schools of nursing. For details write to the Registrar at the university.

● Wayne University, Detroit, is offering to nurses of the state a series of non-credit institutes and workshops on staff education, in cooperation with the Michigan Nursing Center Association, Michigan League of Nursing Education, and the Bureaus of Maternal and Child Health and of Public Health Nursing of the Michigan Department of Health. Among the programs are those on Child Growth and Development, November 28-December 9, with Milenka Herc as leader; Teaching of Parents in Maternity and Infant Services, November 7-11, continued January 16-18, Evelyn Johnsen and assistants, leaders; and Nursing Care of Babies in Health and Disease During the First Year of Life, March 6-8,, Esther H. Read, leader. Also offered are a series of regular meetings for groups with special interests. Newer trends in clinical nursing will be the subject of meetings for public health nurses, to be held April 19, 26, May 3, 10, 17 and 24.

● The time of the CARE Soap Campaign has been extended to December 1. Until that time for every two Swan soap wrappers sent to CARE, Boston 1, Mass., CARE will receive a bar of all-purpose soap for distribution to needy children and families abroad. So far 35 tons of soap has been shipped to Europe for this purpose.

FORM FOR ADVANCE REGISTRATION

# NOPHN Regional Conferences

Note: Do *not* send money. Payment of the registration fee ($2 for 1 day; $4 for 2 days) should be made in person at the conference.

NAME .....

Please print

ADDRESS .....

CITY AND STATE .....

Dates and groups you will attend (please check):

Richmond, Virginia, John Marshall Hotel

December 6, Group 1, School Nursing Conference .....

December 7, General Session .....

Indianapolis, Indiana, Severin Hotel

December 13, Group 1, School Nursing Conference .....

December 14, General Session .....

Are you an NOPHN member ..... Nurse member .....

General member ..... Non-member .....

Please attach list of questions and problems you would like discussed.

Fill out form and return to RUTH FISHER, National Organization for Public Health Nursing, 1790 Broadway, New York 19, New York

Note: Kindly make your own hotel reservations directly with the John Marshall Hotel, Richmond, Virginia, or the Severin Hotel, Indianapolis, Indiana.

*(See also page 514 this issue)*

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# When the problem is Pediculosis Capitis

## Here's how to solve it *Tactfully*

It is embarrassing to the nurse when a parent must be told that a child has lice. Here's how to get around it gracefully, and win the gratitude of the mother.

Send for a supply of the little leaflet prepared by the makers of A-200 Pyrinate Liquid. It is addressed to parents, and tells in sympathetic and diplomatic language the actual *danger* of lice infestation. It also tells these things about A-200:

**A.** A-200 is a sure, fast killer of lice, and their eggs . . . on contact. One 15-minute application is usually sufficient.

**B.** A-200 is non-poisonous, non-irritating, and leaves no tell-tale odor.

**C.** A-200 is easy to use. It is a liquid . . . no greasy salve to stain clothing. Especially recommended for children. At your drugstore, only 79¢.

**LIQUID**

***A-200***

**PYRINATE**

**McKesson & Robbins, Inc.**
**Bridgeport, Conn.**
***Famous for Quality Since 1833***


McKESSON & ROBBINS, INC., Bridgeport, Conn.

Please send me a supply of the leaflet, "Pediculosis Capitis is *dangerous.*"

Name_____

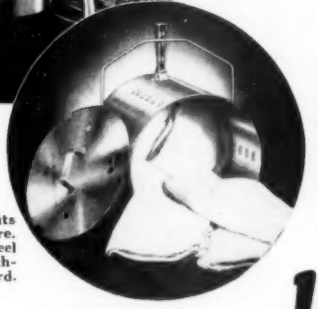
Street_____

City_____ Zone____ State_____

# WHEN POLIO PATIENTS COME HOME

## *Administer Efficient Hot Pack Therapy with*

## *The* VOLLRATH *Portable* POLIO-PAK HEATER



Stands 20½ inches high; fits space 16½ inches square. Complete with Stainless Steel "Pak-Pail," rubber crutch-feet, 12 ft. electric cord. Weighs only 23 lbs.

Now—*for the first time*—visiting nurses can easily administer efficient hot-pack therapy to patients *in their homes*. Can combat the crippling effect of poliomyelitis by continuing treatment started while the afflicted were confined in hospitals! The new, *portable* Vollrath Polio-Pak Heater enables you to bring into any electrically wired home the same safe, simple method of preparing hot packs in quantity as Vollrath's proven hospital unit.

Vollrath's *portable* is a complete unit, simple to operate without tedious, time-consuming training or heavy expense. A nurse can prepare fifteen 12″ x 24″ double-thick hot packs—or equivalent—*at one time*. Can prepare and apply packs at patient's bedside—without fuss, needless labor, or loss of time.

Made of polished Stainless Steel, with no moving parts to wear out, the Vollrath *Portable* Polio-Pak Heater is built for years of service. Prompt delivery!

ADVERTISED IN AMERICAN MEDICAL ASSOCIATION PUBLICATIONS

*The* **Vollrath Co.**

**SHEBOYGAN, WIS.**

**NEW YORK • CHICAGO • LOS ANGELES**

You know, you do more for your patient than you might think . . . .

For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

But good grooming is more than the morning bath and a bright fresh uniform. Because perspiration is a continuous process.

MUM is the safer way to preserve morning bath freshness. You'll love its delightful new floral odor, its creamy texture. And MUM is sure because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

**Why take a chance when you can MUM in a moment?**

***Safer for charm . . .***
***Safer for skin . . .***
***Safer for clothes . . .***


*Product of* BRISTOL-MYERS, 19 West 50 Street, New York 20, N. Y.

# TRUSHAY


## for soft hands that smooth the way thru the day

Now you can have those well-groomed hands *On Duty* as well as *Off Duty*—in spite of the drying damage of frequent scrubbings, soap and water.

**with TRUSHAY that is**

For **TRUSHAY** starts off by being the most luxurious softener that ever smoothed your skin—rich as cream—but without a trace of stickiness. It's sheer delight to use at any time.

**and that isn't all**

For **TRUSHAY** does double duty with its unique "beforehand" extra. Smoothed on *before* frequent washings, **TRUSHAY** protects your hands even in hot, soapy water—guards the skin by helping to preserve its natural lubricants.

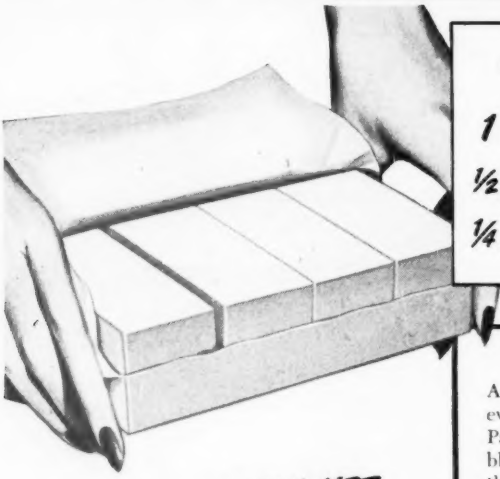
*Begin today to use* **TRUSHAY** *—and when patients admire your well-groomed hands, tell them about the lotion with the "beforehand" extra,* **TRUSHAY.**

**Product of BRISTOL-MYERS • 19 West 50 Street, New York 20, N. Y.**

SO WONDERFULLY CONVENIENT!

# NUCOA

## in the NEW Measure-Pak



**EASY MEASURING GUIDE**

1 print = ½ cup

½ print = ¼ cup

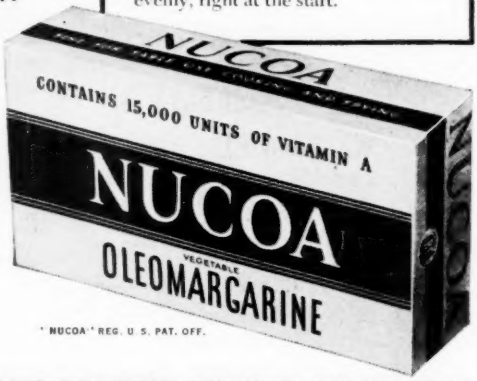
¼ print = 2 tablespoons

**Short Cut to "bowl-mixing"!**

A two-pound bowl-mix is easier than ever—thanks to the new Measure-Pak. You don't have to soften a *solid* block before you begin, it reaches the right mixing temperature faster and more evenly, and it's easier to distribute the pure color wafer evenly, right at the start.

### NEWEST REASON YET FOR COOKING WITH NUCOA

Measure-Pak Nucoa in ¼-lb. prints does away with slow, bothersome spoon-and-cup measuring for good. Just use Nucoa quarters as a scale, and get the exact amount your recipe calls for. A favorite with nutritionists for over 30 years, delicious, churn-fresh Nucoa margarine is enriched with 15,000 units of Vitamin A per pound.




"NUCOA" REG. U. S. PAT. OFF.

**ONLY NUCOA — AMERICA'S LARGEST-SELLING MARGARINE**

**—NOW IN THE NEW Measure-Pak**

## POSITIONS AVAILABLE

WANTED—Child hygiene supervisor, generalized supervisor and public health nurses, Baltimore County Health Department. Population 248,000; suburban, industrialized and rural areas; county seat 8 miles from Baltimore. Generalized service including modern school health program, rapidly expanding up to 50 field nurses. One month's vacation; 5 day, 35¼ hour week; sick leave; retirement plan. For use of personal car, allowance of 7 cents per mile. Supervisor: degree and experience required: salary $3,200 to $3,700. Supervisor with special preparation in child hygiene: $3,500 to $4,000. Public Health Nurses, beginning salary $2,300 (for trainee) to $2,700, depending on experience and education; increases to $3,400. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Three qualified public health staff nurses. Starting salary $2,921.50. Car furnished or allowance; 5 day week. Inservice training. Newly revised generalized program. Opportunity to work under highly qualified supervision. Write: Chairman, Board of Health, City Hall, La Crosse, Wisconsin.

WANTED—Positions for qualified public health nurses, Monroe County Health Department, Monroe, Michigan. A generalized public health nursing program in a semi-rural county, 68,000 population. Located near Detroit, Toledo and Ann Arbor. Salary $3,000.00 plus automobile allowance. Write Medical Director, T. W. Mahoney, M.D., 218 E. First St., Monroe, Mich.

WANTED—Public Health Nurse. Generalized program. Assistant to County Nurse. Mileage allowance. Desirable working conditions. Inquire: O. Damrow, Chairman; Sheboygan County Health Committee, Court House; Sheboygan, Wisconsin.

WANTED—Experienced staff nurse for generalized urban area of 54,000. Staff of 12 nurses, good personnel practices, salary dependent on qualifications and experience. Liberal allowance for personal car which is essential. Write: Public Health Nursing Service, City Hall, Bay City, Michigan.

WANTED—*Public Health Nurse Supervisor*—Minimum requirements—completion of a program of study in public health nursing meeting the requirements of the National Organization for Public Health Nursing, and extending throughout at least one academic year, with bachelor's degree preferred. Salary range, $3,340-$3,808; 40 hour week; retirement plan; liberal vacation and sick leaves. Write: Personnel Department, City Hall, Jackson, Michigan.

WANTED—Qualified orthopedic nursing supervisor; preferably with public health nursing experience and preparation, for crippled children's department in a state institution. Duties include orthopedic nursing consultant service to state staff of 35 public health nurses. Merit system. Beginning salary $3,140. Apply: Executive Secretary, Delaware State Board of Health, Dover, Delaware.

WANTED—Public health nurses for positions on all levels in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57th Street, New York 19, N. Y.

WANTED—Public health nursing supervisor. Beginning salary $4,980-$6,072. Public health training, undergraduate degree, supervisory experience in generalized program and excellent references required. Leaves and other benefits as outlined for senior nurses. Application blanks and details available from Alaska Department of Health, Juneau, Alaska.

WANTED—Senior public health nurse—openings in one nurse services, some on itinerant basis. Starting salary $4,620-$5,313, depending on area to which assigned; annual increase of $180. Public health training, minimum 2 years supervised experience in generalized program, and excellent references required. Thirty working days annual leave, 2 weeks sick leave, workmen's compensation and retirement plan. Application blanks and details available from Alaska Department of Health, Juneau, Alaska.

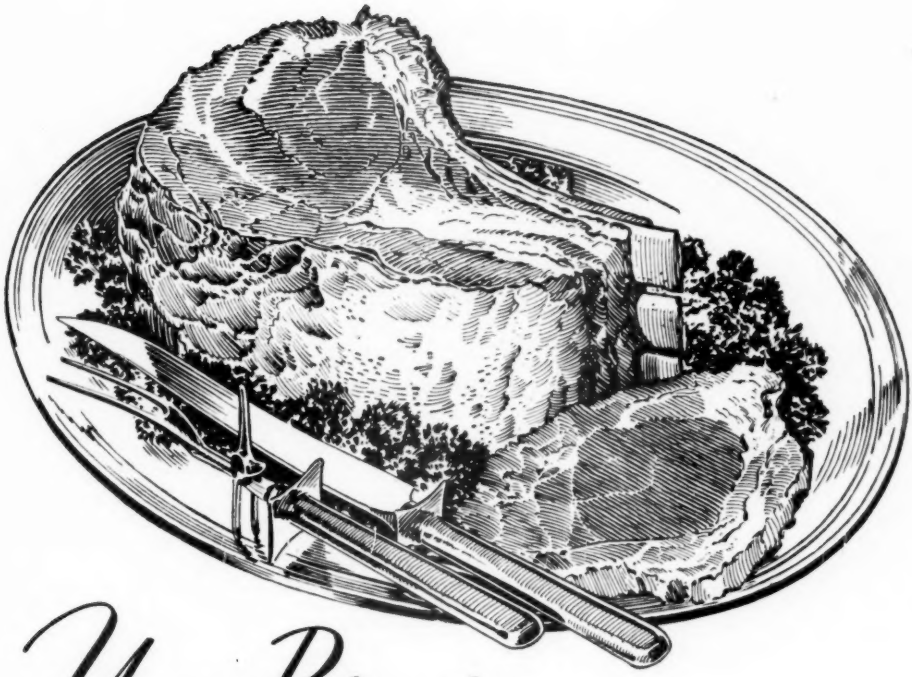
WANTED—One Eating Establishment Sanitarian in capitol city. Salary range now $260-$315 a month. Annual automatic salary increases; semi-annual cost-of-living salary adjustments; car allowance in addition; liberal retirement program. Applications will be accepted until the needs of the service are filled. Write Personnel Division, City Hall, Madison 3, Wisconsin.

WANTED—Two staff Public Health Nurses needed by September (if possible) in large university town. Salary range now $220 to $265 per month. Automatic salary increases; cost-of-living salary adjustments semi-annually; adequate mileage allowance; state-wide retirement program. Applications will be accepted until the needs of the service are filled. Write Personnel Division, City Hall, Madison 3, Wisconsin.

WANTED—Well qualified Public Health Nurses to work in a new Bi-County Health Department planning a field training program. Present salary range $2,940-$3,060. To be increased as soon as training program is established. Car allowance $600 a year. Vacation one month. Reply: Dale E. Sholz, M.D., Lawrence-Wabash County Health Department, Lawrenceville, Illinois.

WANTED—Qualified public health nurse for county health department. Generalized program. Salary: $3,360 to $3,720. Car required—liberal mileage. Write: Wayne County Health Department, Director, Division of Nursing, Eloise, Michigan.

WANTED—Public Health Nurses to fill vacancies in Health Department in New Orleans, La. 5 day, 37½ hour week; annual sick leave 24 days; annual vacation 12 days; 16 holidays observed; in-service training; merit system increases. Beginning salary $160.00 per month; with certificate $170.00; with degree and major in public health nursing $180.00. Write Mrs. Anna Amann, Director, Bureau of Public Health Nursing, 507 Carondelet Street, New Orleans 12, La.



# *Your Patients...*

## And the Meat They Eat

The established relationship between sound dietary planning and a state of maintained good health emphasizes the nutritional importance of meat, man's favorite protein food.

Not only does meat taste good, but of greater significance, it provides a host of nutritional benefits. Developments in the field of nutrition* have proved that complete protein—the kind that meat supplies in abundance—aids in building and maintaining immunity, hastens recovery after acute infectious diseases and following injury and burns, promotes health during pregnancy, aids in the growth and development of husky children, and is needed to maintain everyone in top physical condition.

No matter from what walk of life your patients come, and whether their pocketbooks demand economy or permit satisfaction of that urge for the fanciest cuts, meat gives them full value for their money.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

**American Meat Institute**

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WITH ZIP-IN LINING

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- Navy Blue All Wool Elastique Material
- Fully lined with Skinner's satin-faced wool back lining
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Specially priced **$67.50**

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- For Fall and Spring wear
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Only **$57.50**

## NOPHN STYLE 04

- All Wool Navy Blue Cap
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- Sizes SMALL, MEDIUM, LARGE

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